

Requires improvement**South West Yorkshire Partnership NHS Foundation
Trust**

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXG10	Fieldhead Hospital	Priestley ward	WK1 3SP
RXG10	Fieldhead Hospital	Appleton ward	WK1 3SP
RXG10	Fieldhead Hospital	Johnson ward	WK1 3SP
RXG10	Fieldhead Hospital	Chippendale ward	WK1 3SP
RXG10	Fieldhead Hospital	Waterton ward	WK1 3SP
RXG10	Fieldhead Hospital	Bronte ward	WK1 3SP
RXG10	Fieldhead Hospital	Hepworth ward	WK1 3SP
RXG10	Fieldhead Hospital	Gaskell ward	WK1 3SP
RXG10	Fieldhead Hospital	Sandal ward	WK1 3SP

Summary of findings

RXG10	Fieldhead Hospital	Newhaven ward	WK1 3SP
RXG10	Fieldhead Hospital	Thornhill ward	WK1 3SP
RXG10	Fieldhead Hospital	Ryburn ward	WK1 3SP

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	7
Information about the service	11
Our inspection team	11
Why we carried out this inspection	12
How we carried out this inspection	12
What people who use the provider's services say	12
Areas for improvement	12

Detailed findings from this inspection

Locations inspected	14
Mental Health Act responsibilities	14
Mental Capacity Act and Deprivation of Liberty Safeguards	14
Findings by our five questions	16
Action we have told the provider to take	30

Summary of findings

Overall summary

We rated forensic inpatient secure wards as requires improvement because:

- The nursing staff levels on each ward did not match the number of nurses required to facilitate adequate nursing care. This meant that patient's leave, physical health appointments and ward based activities were cancelled due to the lack of staff.
- The temperature in the clinic room was too high and exceeded the recommended level for the safe storage of medicines. This meant that the stability of medicines was unsafe and that medicines were at risk of being less effective.
- Not all patients with a learning disability or autism had positive behaviour support plans or equivalent in place. This meant that staff would not be providing a consistent approach towards patient exhibiting behaviour which was challenging. This is not in keeping with guidance from NHS England, (Transforming care for people with learning disabilities, 2015).
- Patients were not always receiving 25 hours a week of meaningful activities as recommended by NHS England. This meant that patients were not reaching their potential for recovery and rehabilitation in a timely way.
- Patient care records did not always contain evidence of the patients' involvement in their care. MHA, Mental Capacity Act (MCA) and immediate life support training was available but was not mandatory training for staff. The training being delivered was variable, inconsistent and accurate attendance figures were not kept by the service. The trust had no oversight regarding staff knowledge and understanding of the MHA, MCA or levels of competency for life support.
- Patients' rights, the recording of patients' capacity to consent to treatment and advance decision statements were not consistently recorded in patients care records.
- The care and treatment of one patient in long-term segregation did not meet the standards set out in the MHA code of practice.

- Not all staff had timely access to patients' electronic care records which could compromise the care delivered.
- Food choice availability was inconsistent.
- There was no system in place to ensure that staff were receiving regular supervision as described in the trust supervision policy. Information was collected at ward level but this was not accessible at trust level. This meant that the trust had no data to provide assurance that supervision was being delivered.
- On two wards, compliance with appraisals was 50% and 46% which was not in line with trust policy.

However:

- Staff showed a good understanding of safeguarding issues and there were good links with the local safeguarding authority.
- The facilities provided by the service were clean, spacious and focussed on promoting patients recovery whilst maintaining appropriate levels of security.
- Family and carers were kept informed of patient's care when patients had consented to this. Family and carers were invited to review meetings and felt involved in patient care and decisions.
- We found effective multidisciplinary team (MDT) working. Teams were cohesive with good communication between different professionals and agencies.
- There was a range of professionals involved in patient care which ensured a holistic approach was taken towards patient care.
- There was effective psychology provision available to patients with a range of psychological approaches offered. The psychologist was part of the MDT and contributed to the care planning process. This meant that patients needing psychology could access this service directly and that a psychological approach was embedded in the ward philosophy.

Summary of findings

- Staff followed the trust's complaints policy and lessons were learnt from adverse events. This meant that patients' views were listened to and acted upon.
- Staff were kind and caring and treated patients with respect. This meant that patients felt supported and had a good relationship with their care team.
- There was an effective discharge planning process in place that involved the MDT. This meant that patients ready to move on from the service were not unnecessarily delayed.
- Staff understood and agreed with the mission and values of the trust and felt they were applicable to their role and reflected in the service objectives.
- The senior management team were a visible presence on each ward.
- Each ward was involved in the safer wards programme to help improve the safety and comfort for patients and staff.
- Staff reported that morale was good.
- Staff had the opportunity to give feedback on services and input into service development.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as requires improvement because:

- The nursing staff levels on each ward did not match the number of nurses required to facilitate adequate nursing care. This meant that patient's leave, physical health appointments and ward based activities were often cancelled due to the lack of staff.
- The temperature in the clinic room was too high and exceeded the recommended level for the safe storage of medicines. This meant that the stability of medicines was unsafe and that medicines were at risk of being less effective.
- The service was unable to confirm that staff had received immediate life support training as figures for compliance were not consistently recorded.

However:

- The facilities for patient activities were appropriate to meet the needs of the patients. There were suitable rooms for patients to meet with family members including children.
- The outside space provided for patients was pleasant and included gym equipment. The wards were clean and well maintained. This meant that the patient environment was fitting to promote patient recovery and rehabilitation.
- There was good environmental security in place such as fences, anti-climb measures and air lock doors. This meant that the need for blanket restrictions was reduced and ward safety was enhanced.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- We found that not all patients with a learning disability or autism had positive behaviour plans or equivalents in place. This meant that staff would not be providing a consistent approach towards patients exhibiting behaviour which was challenging. This is not in keeping with guidance from NHS England (Transforming care for people with learning disabilities, 2015).
- Mental Health Act (MHA) and Mental Capacity Act (MCA) training was available but was not mandatory for staff. The training being delivered was variable and inconsistent within the service. This meant that some staff would not be up to date with current MHA or MCA practices and guidance.

Requires improvement



Summary of findings

- Patients' rights, the recording of patient's capacity to consent to treatment and advanced decision statements were not consistently recorded in patients care records.
- Patients were not always receiving 25 hours a week of meaningful activities as recommended by NHS England. This meant that patients were not reaching their potential for recovery and rehabilitation in a timely way.
- The service was reliant upon the use of agency staff however; they did not have access to patients' electronic records. This meant that agency staff would not know the individual needs of patients or be able to deliver the care accordingly.
- Ward nursing staff did not have access to the electronic record system which was used by the GP practice to record patients' physical health needs. They were reliant on healthcare staff migrating this information over to the nursing notes in RiO. This meant that ward staff were not always aware of patients physical health information.
- Forty-six per cent of staff on Priestly ward had not had an appraisal in the last 12 months and 50% of staff on Appleton ward had not. This was not in line with trust policy.

However:

- Care plans were up to date, holistic and showed physical health care screening on admission. This meant that nurses had the relevant information needed to care for patients and that physical health issues were identified and addressed promptly.
- We found effective multidisciplinary team (MDT) working. Teams were cohesive with good communication between different professionals and agencies. There was a range of professionals involved in patient care which ensured a holistic approach was taken towards patient care.
- There was effective psychology provision available to patients with a range of psychological approaches offered. The psychologist was part of the MDT and contributed to the care planning process. This meant that patients needing psychology could access this service directly and that a psychological approach was embedded in the ward philosophy.

Are services caring?

We rated caring as good because,

- Staff were kind, caring and treated patients with respect. This meant that patients felt supported and had a good relationship with their care team.

Good



Summary of findings

- Family and carers were kept informed of patient's care when patients had consented to this. Family and carers were invited to review meetings and felt involved in patient care and decisions.
- Patients were given a welcome pack on arrival to the ward which contained information on procedures and how to raise a complaint.
- Patients were given copies of their care plans and other information that they were encouraged to keep in a folder. This meant that patients were involved in their care and encouraged to participate in their recovery goals.

However:

- Patient involvement was not clearly documented in patient care plans.

Are services responsive to people's needs?

We rated responsive as good because:

- There was an effective discharge planning process in place that involved the multi-disciplinary team. This meant that patients ready to move on from the service were not unnecessarily delayed.
- The service provided adequate facilities for patients with a physical disability. This meant that patients using a wheelchair or other equipment could do so safely.
- There was an appropriate system in place for dealing with patient complaints. Staff followed the trust's complaints policy and lessons were learnt from adverse events. This meant that patients' views were listened to and acted upon.

However:

- We found that activities and planned leave for patients were often cancelled at short notice. This meant that patients' treatment and recovery was delayed.
- Thirteen patients gave negative feedback relating to the food provided.
- Complaints related to limited choice and small portions of the food provided.

Good



Are services well-led?

We rated well-led as requires improvement because:

- The service lacked an effective system to ensure that the Mental Health Act (MHA), Mental Capacity Act (MCA) and immediate life

Requires improvement



Summary of findings

support (ILS) training being delivered was of good quality and was being attended by staff. This meant that the trust had no oversight regarding staff knowledge and understanding of the MHA, MCA or ILS.

- There was no system in place to ensure that staff were receiving regular supervision as described in the trust's supervision policy. Information was collected at ward level but this was not accessible at trust level. This meant that the trust had no data to provide assurance that supervision was being delivered.
- Staffing issues were being managed at ward level and information collected fed in to a monthly dashboard accessible to ward managers and the senior management team. However, staffing on six wards was below those deemed safe for a substantial period of time. There was no long term plan identified to resolve the problems in the future. This meant that the trust was not responding to issues identified within the governance structure.

However:

- All staff were aware of the most senior managers within the service. The senior management team were a visible presence on each ward.
- Each ward was involved in the safer wards programme to help improve the safety and comfort for patients and staff.
- Staff reported that morale was good.

Summary of findings

Information about the service

Fieldhead Hospital is both the headquarters of South West Yorkshire Partnership NHS Foundation Trust and host for a range of specialist inpatient mental health and learning disability services. The hospital's location, on the outskirts of Wakefield, contains mental health wards for working age and older adults, psychiatric intensive care units (PICU) and inpatient facilities for patients who have a learning disability. The site contains both low and medium secure mental health units.

The forensic and inpatient wards were situated at Fieldhead Hospital Wakefield. We visited all twelve wards in the medium secure service at Newton Lodge and the low secure service at the Bretton Centre.

The medium secure wards were situated at Newton Lodge and these were;

- Priestley ward, 17 beds, all male active recovery ward.
- Appleton ward, eight beds, all male admission and assessment for patients with learning disabilities.
- Johnson ward, 15 beds female women's mental illness pathway.
- Chippendale ward 12 beds learning disability recovery pathway.
- Waterton ward, 16 beds male enhanced recovery.
- Bronte ward, seven beds male mental illness pathway admission and PICU.

- Hepworth ward, 15 beds male acute mental illness pathway.
- Gaskell ward, 8 beds.

The low secure wards were situated at the Bretton Centre at Fieldhead hospital, these were;

- Sandal ward, 16 beds all male admissions and assessment.
- Newhaven ward, 16 beds all male learning disabilities pathway.
- Thornhill ward, 15 beds all male.
- Ryburn ward, seven beds all male, pre discharge pathway.

The last routine inspection by the CQC was on 31 July 2013, non-compliance was found against:

- Regulation 11 - Safeguarding people who use services from abuse. Suitable arrangements were not in place which protected patients from the risk of control or restraint being unlawful, or excessive.
- Regulation 15 - Safety and suitability of premises. Patients, and others, having access to the premises were not protected against the risks associated with unsafe or unsuitable premises because of the unsuitable design/layout of some of its premises. Adequate maintenance had not always been carried out.

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett, Retired Medical Director

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team leader: Chris Watson, Inspection Manager (mental health), Care Quality Commission and Berry Rose, Inspection Manager (community health), Care Quality Commission

The team that inspected this core service comprised: a CQC inspector, three specialist advisors and two experts by experience. The three specialist advisors were two nurses and one consultant psychiatrist. An expert by experience is a person with personal experience of using the service.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from managers at two focus groups.

During the inspection visit, the inspection team:

- visited all 12 of the wards and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 31 patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 41 other staff members; including doctors and nurses
- interviewed the managers with responsibility for these services
- attended and observed 12 multi-disciplinary meetings and two care and treatment reviews
- looked at 24 treatment records of patients and 58 prescription cards
- carried out a specific check of the medication management on three wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to 31 patients during the inspection process. Patients said staff were kind and caring towards them and that they felt their care needs were being met. However, 20 patients told us that their leave was regularly cancelled and 16 patients said their ward activities were regularly cancelled at short notice. Patients said that there was not enough nursing staff to ensure that these

duties were carried out. Thirteen patients gave negative feedback relating to the food provided. Five patients complained about the queuing system for food which meant there was limited choice for some. Three patients complained about staff eating the food and the food being tasteless and small portions. Two patients complained that vegan food was not always available.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that staffing levels are appropriate to meet the needs of the patients.
- The trust must ensure that the clinic room temperature is safe for the storage of medicines.

- The trust must ensure that positive behaviour support plans or equivalent are implemented for all patients with learning disability or autism.

Summary of findings

- The trust must ensure that there are effective systems in place to record levels of staff training and supervision.
- The trust must continue with plans to improve the consistency of Mental Health Act, Mental Capacity Act and immediate life support training.

Action the provider SHOULD take to improve

- The trust should ensure that the care and treatment of individuals in long-term segregation complies with Mental Health Act (MHA) code of practice.
- The trust should ensure that the food provision is of good quality.
- The trust should ensure that staff inform patients of their rights and record this in patient notes at regular intervals as set out in the MHA code of practice.
- The trust should ensure that consent and capacity to consent should be assessed and recorded in patient notes in accordance with the MHA code of practice.
- The trust should ensure that access to patient records is available for all relevant staff in order for staff to provide safe patient care.

South West Yorkshire Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Priestley ward	Fieldhead Hospital
Appleton ward	Fieldhead Hospital
Johnson ward	Fieldhead Hospital
Chippendale ward	Fieldhead Hospital
Waterton ward	Fieldhead Hospital
Bronte ward	Fieldhead Hospital
Hepworth ward	Fieldhead Hospital
Gaskell ward	Fieldhead Hospital
Sandal ward	Fieldhead Hospital
Newhaven ward	Fieldhead Hospital
Thornhill ward	Fieldhead Hospital
Ryburn ward	Fieldhead Hospital

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Mental Health Act (MHA) training was delivered at a local level but was not mandatory. The trust did not collate figures for MHA training. We found that staff training and knowledge regarding the MHA was variable.

A MHA review visit was completed on Thornhill ward in February 2016. This review identified some gaps in MHA documentation.

- There were no records of consent or capacity to consent during the first three months of admission.
- There were delays in patients being informed of their rights under the MHA.

However, the provision of an Independent Mental Health Advocate (IMHA) was good. The IMHA visited the wards regularly and was able to attend review meetings where necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust did not provide figures for Mental Capacity Act (MCA) training. MCA training was not mandatory.

The service did not routinely support patients to make advanced decisions about their care. Although paperwork was available to staff, this was not completed.

There were no Deprivation of Liberty Safeguards applications made by the service in the 12 months prior to inspection.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

At the time of the inspection, Newton Lodge physical security measures met the standards for medium secure services as laid out by the Royal College of Psychiatrists. The unit was surrounded by a secure perimeter with anti-climb measures in place to prevent access to the roof. Entry to the unit was through an air lock system, controlled by reception staff. Reception staff also issued keys and alarms to staff. Key management was good and validation checks were in place. All staff and visitors carried personal alarms.

The Bretton Centre similarly met the standards for physical security for low secure services as described by the Royal College of Psychiatrists. There was an external perimeter in place and climb points were not evident, although we were told by staff that one patient had been able to scale the fence on two occasions and their placement on the low secure ward was being reviewed. At the time of the inspection the trust was in the process of building an airlock system of entry, the same procedural security checks were in place across both units.

Staff undertook a key induction prior to holding keys to the unit. All staff we spoke with had a good understanding and knowledge of the physical security measures in place on both units. There was a banned items list and lockers were provided for staff and visitors away from the patient areas for the storage of any items not allowed on the unit. Access to spaces where sharp implements e.g. kitchen knives, utensils, equipment or tools were available was controlled. This was good practice to ensure the safety of patients and staff in the secure setting.

All the wards we visited were clean and presented with good décor and repair. All ward areas were light and bright with single bedroom accommodation for all patients. All bedrooms were en suite in the medium secure area. In other areas patients had access to a sufficient amount of bathroom facilities. Assisted bathrooms were available for those who required disabled bathroom access. Furniture and fittings minimised the potential of being used as weapons, barriers and ligature points. Bedroom doors had observation panels. Some had integrated obscuring mechanisms and others had a temporary curtain covering

the viewing pane. Regular environmental assessments were undertaken to ensure the environment was safe and clean. Patients and carers all told us that the wards were always clean.

Both wards had blind spots and difficulties with observation. These were mitigated with the use of mirrors in some areas, regular nurse observation checks and individual patient risk assessment and mitigation. We were given good examples by the nurses of how the staff managed risk with these environmental difficulties and how they mitigated individual risks in the least restrictive way, for example patients at higher risk were situated in bedrooms within line of sight of nursing stations.

There were dedicated spaces for patients within the building of the medium secure service for education, occupational therapy, psychology and therapy, physical exercise area with a gym and sports hall, self-catering/cooking. Chippendale ward had developed a dedicated relaxation area within the ward area for patients to sit with the use of soft music and technology to aid relaxation. The low secure services had access within the secure perimeter called the Oasis Centre which was fully equipped with therapy rooms, activity and sports facilities. There was also a horticultural area for gardening activities.

There were appropriately decorated and equipped child and family visiting rooms across both areas. All patients had access to a dedicated multi faith area.

All the seclusion rooms allowed for communication with the patient via an intercom. They all had externally controlled lighting, air conditioning and heating. There were no blind spots, they enabled good observation and there were no visible safety hazards. All the seclusion rooms had access to toilet and washing facilities. They all contained a bed, were well lit, and a clock was visible to patients.

Gaskell ward was an eight-bedded ward which was being used as accommodation for one patient who had been in long-term segregation for five months. Prior to this, the patient was in seclusion for an 11 month period. The patient was awaiting transfer to a more appropriate specialist environment for patients with autism. During this time the patient did not have a consistent staff team. This

Are services safe?

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meant that the patient was not able to form any relationships with staff to aid their recovery. In the last three months a small team had been allocated to this ward. This comprised of one qualified learning disability nurse and two nursing assistants which provided some consistency for this patient.

Resuscitation bags and emergency medicines were kept in the reception areas and were regularly checked by staff. The wards had clinic rooms for the storage of medicines. Staff checked fridge and room temperatures regularly and at the time of the inspection these temperatures were high. Records showed that the temperature for the room regularly reached 25 degrees and above. A temperature of 25 degrees is the maximum room temperature recommended for the storage of medicines. There was no air conditioning in these areas and very little ventilation. These temperatures could compromise the stability of the medicines stored in these areas. This meant that the medication given to patients may not be effective.

Patients could visit a fully equipped clinic room within the medium secure unit for examination by a GP or practice nurse. Outdoor space was available for each ward with small courtyards, some containing gym equipment. These were small but pleasantly laid out areas with shelters and seating.

Safe staffing

Across the service there were 142 whole time equivalent qualified nursing staff and 146 whole time equivalent nursing assistants. Vacancies overall were at 2% with six qualified nurse vacancies and staff sickness at 5% overall. Between 1 November 2014 and 31 October 2015 there were 7,336 shifts filled by bank staff to cover sickness absence or vacancies, and 1,783 shifts filled by agency staff to cover sickness, absence or vacancies. Shifts not filled by bank or agency staff totalled 1,626.

Staffing had been estimated and minimum daily staffing levels were set by the trust. However, a large number of the staff and patients we spoke with told us that staffing levels were often lower than the minimum required by the trust. We were told that the high use of agency staff often affected leave and activity levels across the service. Agency staff had a basic induction to the forensic service and subsequently they were unable to escort patients off the wards. They also had limited access to the electronic records system. Appleton ward had made the decision to stop taking new admissions because of high levels of

disturbed behaviour and safeguarding concerns that were not manageable within the staffing ratio. This meant that important nursing duties were not being fulfilled and aspects of patients care plans were not completed.

Patients told us the lack of staff often impacted on their leave and attendance at activities within the unit. Sixteen patients told us that activities had been cancelled because of lack of staff escorts. Staff at the medium secure unit told us that the activity areas such as the sports hall, woodwork workshop and gym were often not utilised because of lack of staff escorts to these areas. Figures collected by the trust for October, November 2015 and February 2016 showed a shortfall in meeting the 25 hours of meaningful activity which should be provided to patients. Twenty patients and three carers told us that their leave had been cancelled due to lack of staff escort.

There was a dedicated primary care team based at the medium secure unit which included two GP's and two nurses. The GP told us that patients could not always make appointments in the healthcare centre because of lack of staff escorts. The GP would often have to visit the ward area to see patients. Two patients also told us that physical health appointments were cancelled due to lack of a staff escort.

Safe staffing levels were monitored by the trust using safer staffing returns. These figures from June 2015 to January 2016 showed that Priestley, Appleton, Chippendale, Bronte and Hepworth wards were regularly under the target set by the trust for safe staffing levels. Newhaven and Hepworth wards had also been flagged as being under safe staffing levels for one month in this period of time.

There was a consultant psychiatrist, psychologist and forensic social worker attached to each ward and care pathway. Each ward and multidisciplinary team also had an allocated qualified occupational therapist. Patients had access to a psychiatrist when required. There was sufficient medical cover during the day and night. Ward rounds for each consultant took place every week. A doctor could attend in an emergency and was available on call out of hours.

Registered staff were appropriately trained with a mixture of mental health and learning disability nurses in all clinical areas.

Mandatory training figures were good across the service, Appleton at 90%, Sandal at 80%, Thornhill 80%, Ryburn

Are services safe?

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83%, Bronte 94%, Chippendale 92%, Hepworth 85%, Priestley 86%, Waterton 93%, Newhaven 93% and Johnson at 85%. Mandatory training did not include the Mental Health Act or Mental Capacity Act. Immediate life support (ILS) training was also not mandatory at the time of the inspection. We were told that this was to be made mandatory from April 2016 and a rolling programme of training would be introduced.

Assessing and managing risk to patients and staff

Risk assessment was in place for all patients. The trust used a locally designed risk assessment tool, risk assessment and management plan. They also undertook historical clinical risk management through a recognised tool HCR20 for all patients. Although we observed patient involvement in the risk discussions at attendance at multidisciplinary team meetings it was difficult to ascertain their involvement in this process from the clinical records we reviewed. The trust had previously introduced 'My Shared Pathway' which was a recovery focused collaborative self-assessment of risk and risk planning along a discharge focused care pathway. Although the paperwork for this was no longer used, some wards continued to use the headings and process of this type of care planning.

Between 1 May 2015 and 31 January 2016 there were 46 incidents of seclusion. Johnson ward accounted for 17 (37%) of all seclusions. One patient had been placed in long term segregation from admission, 16 months. There were 201 incidents of use of restraint 44 of which occurred on Bronte ward. There were 46 incidents which initially used prone restraint, 17 of which occurred on Bronte ward. Prone restraint occurs when patients are held face down on the floor or other surfaces. This is only recommended as a last resort by the National Institute for Health and Care Excellence, (NICE, NG10, Violence and aggression: short term management in mental health, health and community settings, 2015) due to the high risk of injury or obstruction to the patients airways. These figures were in keeping with the national average for secure services. The service held reducing restrictive interventions meetings on a regular basis to reduce the use of prone restraint.

Staff were able to describe practices that amounted to seclusion and long term segregation and clear policies were in place stating when these could be used. The effects of medication were monitored and staff followed NICE

guidance (CG76, Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, 2009) in prescribing and administration of medicines.

Rapid tranquillisation was recorded on an electronic database datix as 'medication was given without agreement', so figures for this were difficult to ascertain. In the nine months prior to inspection there were two episodes recorded as medication given without agreement on Sandal and Newhaven wards.

When physical restraint was seen as necessary staff told us they used the least restrictive hold to maintain safety. Staff were trained to turn patients immediately if the patient was face down in a floor restraint.

Staff received mandatory training in safeguarding. Safeguarding training took account of both adult and child safeguarding. Staff showed a good understanding of safeguarding issues and explained how to make a safeguarding alert. There were good links with the local safeguarding authority. Safeguarding information was displayed in the wards. A safeguarding policy and procedure was available for staff guidance. Patient's safeguarding concerns were reported and acted upon in a timely way.

There were 10 ongoing staff disciplinary actions underway at the time of the inspection.

There were multi-agency public protection arrangements in place where necessary for patients at high risk of offending.

Physical health assessments were carried out on admission. Full physical healthcare checks had been completed in the past 12 months and the primary care nurses also carried out therapeutic drug monitoring for patients prescribed medicines such as clozapine or lithium, to ensure their physical wellbeing.

Access to personal mobile phones and the internet was risk assessed by the MDT and included in patients' care plans.

Track record on safety

There was one reported serious incident of alleged abuse of a patient between the 30 June 2014 and 19 September 2015. We found that there were systems in place to investigate serious incidents, take action and share the learning with relevant staff.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Reporting incidents and learning from when things go wrong

The forensic service used the datix electronic system of incident recording. All staff with the exception of agency staff were able to input incidents onto this system, although this tended to be qualified nursing staff. Incident information was analysed and discussed within the governance framework. Serious incidents from across the service were actioned and lessons learned shared with all staff. Staff were able to give good examples of lessons learnt from across the service.

Duty of candour

Managers had been trained in duty of candour and the aim of this training was to cascade this to all frontline staff, figures for the amount of frontline staff trained were not recorded. Staff we spoke with however had a good understanding of the duty of candour and were able to give any clear examples of when this was used.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We examined 24 care records of patients. They contained care plans that were up to date and holistic. There was evidence of physical healthcare being assessed on admission and this was monitored as necessary. However, eight care plans were not personalised and six were not recovery focussed.

Ward managers, nursing staff and consultant psychiatrists explained that comprehensive assessments were completed prior to admission to each ward. These were completed by senior management, consultant psychiatrists and nurses if the patient was new to the service. Staff told us that the majority of admissions were transfers from other wards within the hospital. Nursing staff from the admitting ward would attend a multidisciplinary meeting to discuss the patients' needs and suitability. This was in line with the trusts admissions policy.

Information needed to deliver care was stored securely on the RiO computer system. This included care plans and risk assessments. The trust was transitioning from an older version of RiO to a newer version. Other information such as medical notes, previous tribunal reports and Mental Health Act documentation was stored separately in paper records. These were stored in cupboards within locked offices. Bank staff had access to the RiO system; however, agency staff did not. This meant that agency staff would not know the individual needs of patients or be able to deliver the care accordingly.

Physical health records were stored on a separate electronic system by the GP and practice nurses, this was called 'system one'. This caused some difficulties in communication and duplication of records. Ward nursing staff did not have access to this system and relied on the healthcare staff migrating this information over to the nursing notes in RiO. This meant that ward staff were not always aware of patients physical health information. There was initiative in the Trust to enable staff to have a read only access to system one.

Best practice in treatment and care

Staff told us that when prescribing medication, National Institute for Health and Care Excellence (NICE) guidance was followed, (CG76, Medicines adherence: involving patients in decisions about prescribed medicines and

supporting adherence, 2009), along with recommendations from the Royal College of Psychiatrists, trust policy and British National Formulation (BNF) limits. However, we examined 24 patient prescription records and found three patients were prescribed medication above BNF limits with no physical health monitoring in place. This included patients who were prescribed regular medication and regular medication with as required medication in addition.

Psychological therapies as recommended by NICE were available on all wards. These included:

- anger management
- cognitive analytic therapy
- cognitive behavioural therapy
- eye movement desensitisation and reprogramming
- horticultural therapy
- life minus violence
- life minus violence: harmful sexual behaviour
- mental health awareness
- moving on group
- psychosocial interventions
- schema therapy
- self-harm programme
- sports and exercise therapy
- substance misuse

Psychologists were part of the multidisciplinary team structure. Each ward had a dedicated psychologist who was able to provide assessments and treatments to patients based on needs identified in individual care plans.

Physical healthcare was accessed via the local GP service that could visit the wards and use the facilities in the clinic rooms for routine physical health checks. Specialist healthcare could be sought if necessary. Two patients told us that appointments for smear tests, opticians and dentists were frequently cancelled due to lack of available staff to provide an escort.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Recognised rating scales to assess and record severity and outcomes of patient care were used by staff. These included health of the nation outcome scales and the recovery star.

We found little evidence of positive behavioural support (PBS) plans or equivalents in the records we looked at. We were told that the trust would only implement positive behavioural support plans if a specific team approach was required or for patients with autism. They told us they had 15 patients with a positive behavioural support plan in place. However, one patient in long term segregation with autism and challenging behaviour did not have a positive behavioural support plan in place at the time of the inspection.

The trust explained that most patients with learning disability or autism have their needs met within the care planning approach process provided in mental health settings. PBS plans or equivalents were not available to all patients with a learning disability or autism. PBS plans are an intrinsic part of the treatment process for patients with learning disability or autism as defined by guidance from NHS England (Transforming care for people with learning disabilities, 2015). We found that the senior management team did not have a clear understanding of PBS plans.

Wards had a target of achieving 25 hours a week of meaningful activities as recommended by NHS England. We examined data for February 2016 and found that low secure services were meeting this target. However, medium secure wards and Newhaven ward were not. Medium secure services were achieving 67% and Newhaven ward achieved 62%. This meant that patients were not receiving the correct care to optimise treatment and recovery.

Clinical audits were completed by clinical staff. These included consent to treatment audits, Sainsbury mental health risk assessment audits, historical clinical risk management-20 audits and Mental Health Act section 132 audits. Information from the audits was analysed, action plans implemented and learning shared with relevant staff.

Skilled staff to deliver care

Each ward had access to staff of various different disciplines and grades. This included medical staff, psychologists, occupational therapists, technical instructors and activity coordinators. Newhaven ward had a community liaison nurse. Pharmacist and pharmacy technicians also provided weekly input into the wards.

Staff were experienced and qualified in their relevant roles. Specialist training was available and staff had access to in-house training in autism and learning disabilities specific topics. There were four preceptorship nurses who were placed on four wards, Chippendale, Bronte, Sandal and Newhaven. Newly qualified nurses told us they were well supported by senior staff members within the service.

All staff, including bank staff, were expected to complete a corporate and local induction. Temporary agency staff were expected to complete a local induction to the service. During the inspection process we found that staff inductions were completed as necessary and contained relevant information.

We examined the trust's staff supervision policy which stated that staff should receive 12 hours of clinical supervision per year. Staff should also keep records of this supervision and be able to demonstrate during their annual appraisal that their supervision records met the 12 hour minimum standard. The trust was unable to provide figures regarding supervision data. However, during the inspection process we saw paper records of staff supervision that showed some regular supervision occurred and was documented. Staff also spoke about informal supervision that they received from managers and peers.

The overall percentage of non-medical staff that had an appraisal in the last 12 months was 83%. The exception was Priestley and Appleton wards. Forty-six per cent of staff on Priestley ward had not had an appraisal in the last 12 months. For Appleton ward the figure was 50%.

There were 14 (100%) doctors revalidated during the last 12 months for this core service.

Staff had access to regular team meetings which included daily handover meetings and regular multidisciplinary team meetings. Staff described working in cohesive teams with excellent communication.

We found that the trust dealt with poor nursing care appropriately. Issues were dealt with promptly and it was standard practice to suspend staff if allegations were made. We saw records that showed ten staff members from this core service had been suspended in the 12 months prior to inspection.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Multi-disciplinary and inter-agency team work

Staff participated in regular and effective multidisciplinary team (MDT) meetings. Staff said these occurred twice weekly and that they enhanced communication and teamwork. We observed 12 MDT meeting and two patient care and treatment reviews. We found that the MDT meetings addressed issues relating to the Mental Health Act and Mental Capacity Act and that staff were familiar with the needs of the patients. Patients were advised that family or carers could attend and that an advocate was also available. However, no advocates attended any of the meetings that we observed.

We examined the handover protocol and the communications documents. We found that these were effective and contained objective information regarding patient's mental state.

Forensic social workers were attached to each care pathway and had responsibility for a number of patients. Some of these were also approved mental health professionals (AMHP's) who undertook responsibilities under the Mental Health Act. These social workers worked in liaison with outside agencies, relatives and carers, contributing to discharge planning through the care pathways which was detailed within the care programme approach (CPA). Community case workers and outside agencies were invited to all discharge planning and CPA meetings and efforts were made to maintain contact throughout a patients stay.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The trust did not routinely capture compliance information around Mental Health Act (MHA) training, as this was not identified as mandatory training. We found that training was provided at a local level. However, we were unable to ascertain the quality or quantity of this training as this data was not captured by the trust.

Thornhill Ward had a MHA review visit in February 2016. During this review we examined three sets of patient records. We found treatment had been properly authorised either by the responsible clinician or a second opinion appointed doctor and the most recent T2 or T3 treatment certificates were kept with patients' medication cards. These were the legal authority to administer medication to a detained patient. However, we could not find any records of assessment of patients' consent and capacity to consent

during the first three months of treatment. This meant that it was unclear if patients had consented to treatment or had the capacity to consent to treatment following admission into the service.

There were records of patients having been informed of their rights on admission, and in two cases reminders had been given within the last two months. However prior to that there was a gap of 12 months in informing patients of their rights, and one patient had not been informed of their rights since January 2015.

In each of the cases we examined MHA admission documents had been properly completed, received and scrutinised. We examined section 17 leave and found that this had been properly authorised by the responsible clinician. We found detailed leave care plans and evidence of risk assessments being undertaken prior to leave events. However, the one patient we met with complained of their planned escorted leave being frequently cancelled due to there not being sufficient staff to provide the escort, and staff confirmed that this did happen often. The problem was further confused by the practice of authorising "blocks" of leave at nursing staff's discretion which in some cases gave patients an expectation that they would be able to go on leave more often than was realistically achievable.

The Independent Mental Health Advocate (IMHA) service was provided by Cloverleaf who were an advocacy service based in Dewsbury. The IMHA visited the ward each week on ward round days as well as attending the weekly ward meeting and care programme approach (CPA) reviews. Leaflets publicising the IMHA service were on display on the ward.

For one patient in long term segregation we found no evidence of a safeguarding referral to the local authority. However, the trust social work team were involved and took part in decisions regarding plans for future placements.

Good practice in applying the Mental Capacity Act

South West Yorkshire Partnership did not routinely capture compliance information around Mental Capacity Act (MCA) training, as this was not currently identified as mandatory training. We noted that there were advanced decision statements and capacity assessment templates in the RiO electronic system, although we also noted these were not routinely completed.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Between 1 November 2015 and 31 January 2016, there were no DOLS applications made for this service.

Are services caring?

Good 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

We observed staff interacting with patients in a respectful and caring way. Staff were discreet and provided practical and emotional support.

Patients told us that staff were kind and caring towards them and that they felt staff were trying their best to help them.

We observed staff demonstrating a good understanding of patient's needs. This was evident in multidisciplinary team meetings, care and treatment reviews and in the general ward environment. We saw staff showing an in depth and up to date knowledge of patients mental health needs. Patients told us that staff understood their individual needs and that staff were approachable when needed.

The involvement of people in the care that they receive

Patients were invited to visit the ward prior to admission. They also received a welcome introduction pack on arrival to the ward which contained information on procedures and how to raise a complaint.

We examined 24 care planning records and found that 44% did not contain evidence of patient involvement. However, we observed 14 patient reviews which all demonstrated good patient participation in the care planning and risk assessment process. Patients were actively encouraged to

maintain independence by staff. Patients we spoke to said they felt involved in their care. Patients had folders which contained care planning information. This meant that patients were involved in their care but this was not recorded consistently in patient care notes.

Advocacy services were provided by Cloverleaf advocacy services. Cloverleaf provided both Independent Mental Health Advocacy services and Independent Mental Capacity Advocacy services. We found that patients were routinely asked if they would like an advocate to attend their review meetings. However, during the inspection visit we observed that advocates were not in attendance at these meetings. Patients told us they knew how to access an advocate and that advocates regularly visited the wards. Staff we spoke to knew how to refer patients for an advocate if they agreed or lacked capacity to agree.

Families and carers were routinely invited to attend patient review meetings with the patients consent. Families and carers told us they were kept up to date by telephone or letter if they were unable to attend review meetings.

Carers explained how they could give feedback at the carer group meetings and that if necessary they could approach ward staff for information if needed.

Advanced decisions were not in place for patients. Staff did not routinely seek to support patients to make advanced decisions for periods when they lacked capacity.

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

We examined the admission policy and spoke to staff and patients regarding the admission process. We found that prior to admission; patients were invited to visit the ward. This was care planned in advance to ensure safety of the patient and others. Patients then received a welcome, introduction and orientation to the ward provided by either the named nurse, nurse in charge or ward manager.

The average bed occupancy over the last six months for the forensic service was 91%. All of the wards were above the 85% limit as recommended by research undertaken by the Royal College of Psychiatrists. This research indicated that where wards were running at over 85% bed occupancy, this could have a negative impact on patient care. Occupancy rates for each ward were,

- Waterton ward 98%
- Ryburn ward 98%
- Johnson ward 95%
- Newhaven ward 95%
- Bronte ward 91%
- Thornhill ward 90%
- Hepworth 89%
- Chippendale ward 89%
- Sandal ward 88%
- Priestley ward 86%
- Appleton ward 86%
- Gaskell ward (ward where one patient was nursed)

There were no patients placed out of area in the six months prior to inspection. There was a waiting list in place for patients needing assessment and admission to the service. Ward managers explained that the referral list was discussed at the bed state meetings by the senior management team and allocated as appropriate. At the time of inspection there were 152 beds in total, of which 138 were occupied and 14 were vacant.

There was a clear pathway for patients with a learning disability being newly admitted to the service. Appleton ward was a designated male learning disability admission

and assessment ward within the medium secure service. Staff carried out a 12 week period of assessment which included various assessment tools and plans being implemented.

We looked at the care records for patients with learning disability or autism. We found that care and treatment reviews were completed for the majority of this patient group as recommended by the Mental Health Act Code of Practice. Patient discharge plans were discussed and plans implemented were appropriate. However, the patient in long-term segregation had not received regular reviews and discharge planning was unclear.

Patients on leave from the ward always had the same bed to return to. Leave was usually for short periods.

Patients were not transferred to other wards within the unit or hospital unless this was clinically necessary. Staff told us that patients would move wards if there were compatibility issues with other patients or they were moving along the care pathway to less secure accommodation.

We examined the trust forensic discharge planning audit for 2015 to 2016 which showed good evidence of appropriate and timely discharge planning. We spoke to ward managers and nursing staff who explained that discharge planning occurred as part of the multidisciplinary team meeting process and was effective and comprehensive. However, delays could occur due to external factors such as a lack of funding arrangements, ministry of justice status and placement availability. Internal delay factors included the social worker not being present and the patient's recent progress. In the last six months, there were four delayed discharges for the forensic service.

In the last six months, there were no patients readmitted within 90 days of discharge from the service. This indicates that discharge planning was effective in meeting patients' needs.

The average length of stay for patients discharged in the last 12 months was 829 days. The average length of stay for current patients was 739 days. The average length of stay per ward was:

- Appleton 395
- Bronte 217
- Chippendale 992

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

- Hepworth 297
- Johnson 1010
- Newhaven 952
- Priestley 670
- Ryburn 1196
- Sandal 855
- Thornhill 600
- Waterton 945
- Gaskell (ward where one patient is nursed)

These figures are in keeping with the national average for forensic services.

If necessary, male patients in the medium secure service could access a psychiatric intensive care bed on Bronte ward. Female patients requiring PICU facilities could be transferred to another hospital. Staff explained that using the ward seclusion facilities would be the first option prior to making a referral to another unit.

The facilities promote recovery, comfort, dignity and confidentiality

We visited each ward and found that they had a sufficient number of clinic rooms, activity rooms and quiet areas for patients to meet their visitors. However, the activity area on Bronte ward was too small to allow staff to carry out activities and there was limited space in the quiet area on Waterton ward.

Patients had access to private space to make telephone calls. However, the telephone on Bronte ward was in need of repair. Where possible patients could access mobile phones following an individual risk assessment.

Each ward had access to outside space which was supervised. The courtyard area on Waterton ward was bare and unattractive.

We spoke to 31 patients and examined the food menu which was rotated on a weekly basis. Thirteen patients gave negative feedback relating to the food provided. Five patients complained about the queuing system for food which meant there was limited choice for some. Three patients complained about staff eating the food and the food being tasteless and small portions. Two patients complained that vegan food was not always available.

Patients had access to drinks and snacks 24 hours a day. Patients on some wards had direct access to drinks and snacks and others needed to ask a nurse. This was dependant on the risk assessment of the patient group on each ward.

Patients were able to personalise their bedrooms. However, we found that there was limited space for belongings due to the secure nature of the environment.

Patients had places to store the personal belongings safely. This was provided by either patients having a safe in their room or having the keys to their room. This was based on individual risk assessments and ward policy.

Access to activities was varied. Occupational therapy staff provided a range of activities based on patients' needs and interests. Nursing staff also provided activities at evenings and weekends. However, we spoke to 31 patients and 16 complained that activities were frequently cancelled due to a lack of staff. Ward managers and nursing staff also confirmed that activities were cancelled at short notice. Activities were especially limited at weekends. This meant that patients could not utilise their time with meaningful daytime activities that would aid recovery.

The trust had a reducing restrictive physical intervention group and action plan in place. We examined the minutes and plans and found that appropriate actions were being complied with.

A patient led assessment of care and environment was completed in 2015. This showed that forensic inpatient services scored 96% for privacy, dignity and wellbeing. This was above the England average of 87%.

Meeting the needs of all people who use the service

Disabled bathrooms were available for patients with physical disabilities. There was a nurse call alarm installed in the bathrooms and patient were risk assessed on admission regarding mobility issues. Corridors were wide enough for wheelchair access and wheelchair slippers were provided to help maintain ward hygiene.

Leaflets were available in other languages. Braille and easy read versions were also available. Access to interpreters was available upon request.

Information was available to patients regarding treatment options. This was stored on the computer system and printed for patients when necessary. Information regarding

Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

physical health such as smoking, diet and diabetes were available in leaflets on the notice board. Leaflets were on display regarding the advocacy services and how to complain. Wards also had a "you said, we did" notice board which contained the action plans arising from patient community meetings.

Food was available to meet the needs of patients with specific dietary requirements such as diabetic, gluten free, vegetarian, vegan and halal. However, two patients told us that vegan food was not always available but that this had been discussed with staff and action was being taken. Both patients said they were involved in the decisions relating to food improvement.

There was a multi-faith room available for all patients to use. Three patients told us they accessed this regularly and that their spiritual needs were met.

Listening to and learning from concerns and complaints

A total of 12 complaints were received regarding the forensic service in the 12 months prior to inspection. All of the complaints were upheld and none were referred to the Ombudsmen.

Appleton had the highest number of complaints with three followed by Hepworth, Johnson and Sandal wards who all received two.

Seven compliments were received in the last 12 months, with Chippendale and Sandal wards receiving the most with two each.

Patients were given information regarding the complaints process within the welcome pack they received on admission. This included the internal customer services contact details and the independent advocacy services. Patients could also raise complaints during the patient community meetings. We saw evidence of feedback from this on the patient noticeboards.

Staff told us they would try to resolve any complaint at a local level. However, if this was not successful they would refer the complaint to the ward manager. Staff were aware of how to involve patient advice and liaison services to support the patient.

We examined the complaints data and saw evidence of complaints being investigated and the appropriate action being taken. This process involved staff and lessons learnt processes were in place. Staff were able to give examples of this happening in practice.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

Staff we spoke to were able to demonstrate knowledge of the trusts mission and values which were;

- enabling people to reach their potential and live well in their community
- honest, open and transparent
- person first and in the centre
- improve and be outstanding
- relevant today and ready for tomorrow
- families and carers matter

Staff agreed with the mission and values and felt they were applicable to their role and reflected in the service objectives.

All staff were aware of the most senior managers within the service. The senior management team were a visible presence on each ward.

Good governance

We found that there were adequate systems in place to ensure that mandatory training was received by staff. However, this did not include Mental Health Act (MHA), Mental Capacity Act (MCA) or immediate life support training which was devised and delivered at a local level. There were no effective systems in place to ensure that all staff were up to date with this training. This meant that the trust could not be assured that staff had received the necessary training in the MHA, MCA or immediate life support.

There were effective systems in place to record staff appraisal rates. However, there were no effective systems in place to record staff supervision rates within the service. This meant that the senior management team did not have oversight of staff supervision levels.

Shifts were covered by staff with the correct grade and experience for the role. There was an appropriate mix of nurses from a learning disability and mental health background and preceptorship nurses were allocated evenly amongst the wards. Shifts were not always covered by the correct amount of staff and this was highlighted by

the trusts safe staffing return system. This meant that the senior management team were aware of the staffing issues on each ward but lacked a long term plan to resolve the problems.

There was good administrative support to enable nursing staff to concentrate on direct patient care tasks.

Incidents were reported by staff and examined by the trust for any trends or themes for the service. Information and lessons learnt were fed back to staff to ensure safer practice.

There was a complaints process in place and opportunities for service user feedback. Issues arising from this were discussed with staff and displayed on ward noticeboards.

The service used key performance indicators to gauge performance of each ward. Data was collected monthly and displayed on a dashboard that was accessible to ward managers and other members of the senior management team. Data included:

- staff sickness rates
- staff training compliance figures
- staffing levels per ward
- bed occupancy rates per ward
- complaints received
- safeguarding referrals
- patient questionnaires
- staff questionnaires
- patient active engagement hours
- risk assessments
- smoking cessation
- carer support
- clinical leadership
- physical healthcare

This information was used to develop improvement plans where issues had been identified.

Ward managers were supported by an effective administration team. This helped maintain the efficiency of the service.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Ward managers explained they had enough authority to do their job. Risk issues were discussed during monthly supervision and managers meetings. The trust risk register was centrally managed and staff could submit information for discussion via the management structure. We examined the risk register for forensic services. The lack of staff supervision and low staffing levels were included on the register. However, there was no long term action plan to address these issues.

Leadership, morale and staff engagement

Staff surveys were regularly completed. These included wellbeing at work surveys and culture of care barometer surveys. Results from these surveys were discussed in business delivery unit meetings and action plans developed and acted upon.

Staff sickness rate was 5%, slightly above the England average of 4.6%. Staff vacancy rate was 2% for the forensic service. Wards with high sickness and absence rates would use staff from other wards to help cover the shortfall. Ward managers also used bank and agency staff to cover nursing shifts. Where possible bank staff were given short-term contracts to ensure patients had continuity regarding nursing staff. The senior management team were made aware of staff sickness and absence rates via the dashboard system and regular manager meetings.

Issues of bullying and harassment were dealt with quickly and professionally. Staff stated that their managers were

supportive and approachable and that they could raise issues without fear of victimisation. One member of staff we spoke to explained they had reported bullying and harassment and this was dealt with appropriately.

Staff reported that morale was good and that working in a multidisciplinary team (MDT) gave them good job satisfaction.

We found that there were opportunities for leadership development for ward managers. This included middle ground training, (training on how to deliver the trusts strategic agenda) and magnificent seven training (leadership and management skills training).

Team working and mutual support was effective on each ward. This was evidenced in MDT meetings and staff feedback in interviews and staff surveys.

We found that staff had the opportunity to give feedback on services and input into service development. Feedback was obtained via team meetings, staff surveys, supervision and appraisals. Feedback from staff was discussed by the senior management team and staff were invited to be involved in ideas and decision making to resolve any issues.

Commitment to quality improvement and innovation

Each ward was involved in the safer wards programme to help improve the safety and comfort for patients and staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>We found that there was not enough nursing staff to ensure that important nursing tasks were completed.</p> <ul style="list-style-type: none">• Meaningful activity targets were not being met.• There was a high level of bank and agency staff used who were unfamiliar with the wards.• Data provided by the trust showed that the wards were regularly breaching their own targets on minimum staffing levels.• Patients we spoke to told us there was not enough staff and too many agency workers.• There was no long term plan to resolve the staffing problems. <p>This meant that patient activities and leave entitlement were often cancelled due to the lack of staff.</p> <p>This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met;</p> <p>We found that medicines were not being stored in a safe way.</p> <ul style="list-style-type: none">• The temperature recorded in the clinic room regularly exceeded the maximum level.• There was no climate regulation in the clinic room.

This section is primarily information for the provider

Requirement notices

This meant that medicines were not being stored at the correct temperature to maintain their stability and effectiveness.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met;

We found that patients with learning disability or autism did not have positive behaviour support (PBS) plans or equivalent.

- Care records showed that very few patients had PBS plans or equivalent.
- The trust had not implemented PBS plans or equivalent until recently.
- Staff showed a lack of knowledge and understanding of PBS plans or equivalent.

This meant that patients with learning disability and autism were not receiving the correct care and treatment as recommended by the Mental Health Act Code of Practice.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met;

We found that there were no effective systems in place for the trust to maintain oversight in relation to staff training and staff supervision.

- The trust did not collate figures on Mental Health Act, Mental Capacity Act and immediate life support training at a governance level.
- The trust did not record data regarding staff supervision rates at a governance level.

This meant that the trust was not assured that staff were adequately trained or supervised.

This was a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014