Good

Black Country 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)
TAJ11	Heath Lane Hospital	Gerry Simon Clinic	B71 2BG

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership NHS FT. 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 Black Country Partnership NHS FT and these are brought together to inform our overall judgement of Black Country Partnership NHS FT.

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	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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Summary of findings

Overall summary

We rated the Forensic inpatient/secure wards as good because:

- The security specifications regarding fencing, environmental searches and access to the clinic met the National Minimum Standards.
- Staff knew how to report and record risk incidents, near misses, raise safeguarding alerts and there had been no serious incidents in the past 12 months. All staff had personal electronic alarms and access to ligature cutters, which were available at strategic points around the clinic. Staff were up to date with physical interventions training (restraint) and knew how to implement.
- Patients' care and treatment was aligned with National Institute for Health and Care Excellence guidance, the Mental Health Act Code of Practice (MHA CoP) (2015), Transforming Care (NHS England 2015) and the British Institute of Learning Disabilities (BILD). Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- The multidisciplinary team worked well together. Each profession contributing towards patients' care and treatment from their expert professional perspective.
- All patients had relevant and detailed risk management plans, which followed a positive behaviour support model. This is aligned with the Mental Health Act Code of Practice (2015), and 'Positive and Safe' (Department of Health 2014).
- Seclusion was used rarely and rapid tranquillisation was not used and facilities complied with national standards and the Mental Health Act Code of Practice (MHA CoP 2015).
- The clinic was clean and cleaning records were up to date and displayed on the wards' walls.
- Medicines were safely stored and safely managed.
- We observed staff treating patients with kindness, dignity, compassion and respect and staff spoke to us in respectful terms about patients.
- There was a clear vision and set of values in the Trust.

However:

- There were a number of potential ligature points throughout the three wards and in the adjoining areas of the clinic and the physical layout of the ward meant there were not clear lines of sight. The configuration of the clinic was circular. This meant that corridors curved so it was not possible to see very far without physically moving and following the curve of the corridor.
- Staff we spoke with understood the Mental Capacity Act (MCA) and how mental capacity is decision specific and can fluctuate. The trust has policies to support staff in understanding the MCA, however, low numbers of staff had attended Safeguarding Adults Level 2 and Level 3 training and no staff had attended Mental Capacity Act training.
- The Trust Seclusion policy was not fully compliant with the MHA CoP (2015) in terms of ending seclusion.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There were a number of potential ligature points throughout the three wards and in the adjoining areas of the clinic. Although, these had been identified by the staff, there was no time frame for completion of the works
- Some of the fixtures and fittings on the wards were damaged or worn.
- The physical layout of the wards meant there were not clear lines of sight.
- The Trust Seclusion policy was not fully compliant with the MHA CoP (2015) in terms of ending a seclusion episode. The ward manager was not aware that a seclusion episode can only be terminated by the nurse in charge following consultation with medical staff.

However:

- There had been no serious incidents or 'never-events' in the past 12 months. Staff knew how to report and record risk incidents and near misses. Staff knew how to raise Safeguarding alerts.
- All staff had personal electronic alarms and three sets of ligature cutters were available at strategic points around the clinic.
- All patients had comprehensive risk assessments using recognised assessment or screening tools and up to date, relevant risk management plans. There was evidence of patient participation in developing these plans.
- All patients had relevant care plans and care records were stored securely.
- The Modified Early Warning Score tool (MEWS) was in use to monitor patients' physical health following any incident where patients had been subject to physical intervention.
- The clinic was clean. Clinical waste was managed and disposed of safely. Cleaning records were up to date and displayed on the wards' walls.
- Medicines were safely stored and safely managed.
- All emergency equipment was present and regularly checked.
- Staffing levels mostly reflected what the planned staffing establishment should be and temporary staff were used to fill vacant shifts.

Summary of findings

Are services effective?

Good

We rated effective as good because:

- Patients care and treatment was aligned with NICE (National Institute for Health and Care Excellence) guidance, the Mental Health Act Code of Practice (MHA CoP) (2015), Transforming Care (NHS England 2015) and the British Institute of Learning Disabilities.
- Concordance with NICE guidance was monitored through the 'Positive Development Group' which has been set up by the learning disability division.
- All patients' medicines were within British National Formulary limits.
- Patients had their needs assessed and their care plans delivered in line with evidence-based guidance, standards and best practice.
- There was no evidence of any discriminatory practice on the basis of age, gender, gender re-assignment, race, religion, sexual orientation or disability.
- Patients had Care Programme Approach meetings every three months to discuss their progress, and to identify any additional treatment needs required to support progress towards discharge.
- Care plans were current and most had been evaluated within the time frame indicated on them. Care plans were available in easy-read format.
- All Mental Health Act (MHA) and Mental Capacity Act (MCA) documentation was current and completed correctly.
- Outcomes for patients were measured using the Health of the Nation Outcome Scales- Secure tool.
- The prescription of PRN (Pro re nata – as required) medicine was reviewed and the rationale for its continued prescription was documented clearly on the 'PRN rationale plan' in the patient's care records.
- The Gerry Simon clinic participated in the Quality Network for Forensic Mental Health Services and is in the top 40 of rated participating organisations.
- Emergency medical care was sourced from the general hospital. Routine medical care was either provided at the clinic by existing medical staff, or by a local GP and dental care was provided by a local dentist.

However:

- Low numbers of staff had attended Safeguarding Adults Level 2 and Level 3 training.

Summary of findings

- Although no staff had attended Mental Capacity Act training, staff did appear to have a good understanding through Trust policy and practice.
- Some care plans had not been evaluated in the time frame indicated on the document.
- One set of seclusion documents had not been filed with the patient's notes eight days after the seclusion episode.
- The Trust Seclusion policy is not fully compliant with the MHA CoP (2015) in terms of ending seclusion.
- Some physical health assessments on admission had been only partially completed.
- There was no social worker.

Are services caring?

Good

We rated caring as good because:

- We observed staff treating patients with kindness, dignity, compassion and respect and staff spoke to us in respectful terms about patients.
- All relevant information to support caring for patients was stored securely in the nursing office.
- Information relevant to each patient was shared with other teams as appropriate and in a timely manner.
- Patients and their families or carers were involved in making choices about the care provided.
- Patients were partners with the MDT in directing their care.
- Everything at the Gerry Simon clinic was directed at promoting independence at the patient's own pace. This was reflected in the detail of care plans and in the 'My Shared Pathway' document.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The Gerry Simon clinic was set up specifically to deal with males with a mental disorder, including intellectual disability and autism that require specially adapted treatment programmes to complete their rehabilitation.
- Patients' often complex physical health needs were met and monitored well. Patients were given physical health checks weekly by ward staff. Care plans contained detailed information about the care required for physical health needs.
- Smoking cessation support was available for patients if they chose to give up smoking.
- Patients had a CPA meeting every three months. Any unmet needs were identified at the CPA and are then addressed.

- Patients could personalise their bedrooms to reflect their tastes and preferences.
- Local spiritual leaders provided spiritual support to any patients who wished to have their input. Patients were supported to attend spiritual gatherings such as church or mosque if they wished to do so.
- Patients with specific dietary requirements could have those met.
- An interpreting service was available for patients who required help to understand English.
- The clinic was all on the ground floor and had adapted facilities to accommodate people with physical disabilities and people who use wheel-chairs.
- MDT provision to the clinic was good. There was a consultant psychiatrist, a speech and language therapist, a team of psychologists, a team of occupational therapists and activity nurses, nurses, support workers and a pharmacist.
- Patients had a number of ways in which they could make complaints, comments or compliments about any aspect of the service. They could do this through PALS (Patient Advice and Liaison), Advocacy services, talking to any member of staff, Patient Council meetings and community meetings. Feedback was given to staff about any issues which impact care provision.

However,

- The narrow corridors in the building would make manoeuvring a wheel-chair in the environment challenging without some assistance. There are currently no wheel-chair users at the clinic.

Are services well-led?

Good

We rated well-led as good because:

- There was a clear vision and set of values in the Trust. We saw staff putting these into practice.
- Senior managers had the required knowledge, skills and understanding to allow them to inform care provision and support improvements.
- Oversight of reported and recorded risk incidents happened at a local level as well as at the level of senior managers. Emerging themes or trends were identified and addressed.
- Key Performance Indicators (KPI) were used to measure the quality of the "culture of care".
- Benchmarking against NICE (National Institute for Health and Care Excellence) guidelines took place and had identifiable outcomes for the service. Benchmarking is the process of

establishing a standard of excellence and comparing a function or activity, a product, or an enterprise as a whole with that standard. It is used increasingly by healthcare institutions to reduce expenses and simultaneously improve product and service quality.

- Ward staff told us they felt able to raise any concerns without fear.
- The views of staff and patients were sought using questionnaires and surveys. On occasion, external facilitators were brought in to assist with capturing the views of staff and patients.
- Ward staff carried out clinical audits. Various ward staff had responsibility for specific audits which were relevant to their role and skill-set.

However:

- Although ligature risks had been identified in the environmental audit, there were no time frames for completion

Summary of findings

Information about the service

The Gerry Simon Clinic is a 15 bed forensic clinic for men with mental disorder, including intellectual disability and autistic spectrum disorders, who require specially adapted treatment programmes to complete their rehabilitation. The clinic is divided into three separate wards with five beds in each ward. There is a fourth area for activities. There is a large hall for ball games. In addition, there is a 'shared space' with the MacArthur Unit, which includes a conference room, family visiting room, office space, clinical room, as well as reception, gym, vending machine and art room facilities.

Patients are first admitted to the Willow ward. They then move to Sycamore ward, where they will engage in their therapies, and begin to learn the skills necessary for them to live safely in the community. On Cedar ward, patients continue to work towards discharge and take increasing responsibility for their own safety while accessing greater amounts of Section 17 leave.

There is a seclusion room and a de-escalation suite situated adjacent to Willow ward. The seclusion and de-escalation facilities are available for use by all three wards in the clinic.

Bedrooms on Willow ward are not en-suite. Bedrooms on Sycamore ward and on Cedar ward are all en-suite.

Our inspection team

The comprehensive inspection of the Black Country Partnership NHS Foundation Trust was led by:

Chair: Dr Oliver Shanley, Deputy Chief Executive Officer, Hertfordshire Partnership University NHS Foundation Trust

Head of Inspection: James Mullins, Head of Hospital inspections, CQC

Team Leader: Kenrick Jackson, Inspection Manager, CQC

The team was comprised of: Three CQC inspectors, two experts by experience, one consultant psychiatrist, one social worker, one mental health act reviewer and three registered mental health nurses.

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, requested specific additional information from the Trust and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited all three of the wards in the clinic and looked at the quality of the ward environment and observed how staff cared for patients.
- Spoke with 7 patients who were using the service.

Summary of findings

- Spoke with the manager of the clinic.
- Spoke with 12 other staff members; including doctors, nurses, support workers, psychologists, a speech and language therapist, occupational therapists, the service manager and the general manager of the service.
- Attended and observed one care programme approach meeting, one nursing hand-over and a patients' council meeting.
- Looked at 14 medicine records.
- Looked at 12 sets of care records. We pathway tracked four of these sets of care records.
- Carried out a specific check of the medicine management on three wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Attended a focus group with the Clinical Commissioning Group (CCG).

What people who use the provider's services say

- We spoke with seven patients. Five patients told us that they found staff to be very caring and supportive. Two patients told us they found staff attitudes poor at times.
- All patients we spoke with told us they had been involved in decisions and choices about their care, that they had signed their care plans and been offered a copy.
- All patients we spoke with told us that there are enough activities provided for them.
- One patient told us he thinks the physical health care provided is excellent.
- Most patients told us that they have Section 17 leave allocated to them but they do not get to take it. This is likely to be due to the documentation used for Section 17 leave as we found no evidence to support this. The Section 17 leave documentation lists every possible use of leave but does not make it clear to patients that although permission is in place it is there to cover all eventualities. It does not mean that every leave accounted for should be taken on every day of every week.
- All patients we spoke with told us they felt safe in the service.
- All patients we spoke with told us that the food was good in the service.
- Some patients told us they wanted to smoke in the evenings but that there is no smoking on the night shift. This is based on risk assessment.
- All patients we spoke with praised the psychology team at the clinic.

Good practice

- The psychology team provide a wide range of specialised treatments for patients and a range of specialist training for staff.
- The use of collaborative risk assessment and risk management planning.
- The involvement and participation of patients in staff training in relational security and risk assessment and risk management.
- Monitoring concordance with NICE guidance.
- Monitoring the prescribing of psychoactive medicine and providing a detailed rationale for any prescribing.
- Ensuring that service provision is aligned with 'Transforming Care' (NHS England 2015).

Areas for improvement

Action the provider SHOULD take to improve

- The Trust should provide MCA training for staff.
- The Trust should provide MHA training for staff to update them in relevant changes to the MHA CoP (2015).

Summary of findings

- The Trust should review its Seclusion policy in line with the MHA CoP (2015).
- The Trust should provide increased administrative support to the unit to assist with the timely filing of seclusion records in care records.
- The Trust should take action to reduce the risks posed by ligature points in the Gerry Simon Clinic.

Black Country 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
Forensic wards	Gerry Simon Clinic

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.

- All section 17 leave forms to be signed by patients and the patients with whom we spoke told us that they had copies of their leave forms.
- Hearings and tribunals took place as per patients' rights and wishes. The Second Opinion Appointed Doctors (SOADs) had reviewed care as required by the MHA.
- Patients had their Section 132 Rights presented to them on a regular basis and it was documented by staff whether they had understood them.
- We were told that an Independent Mental Health Advocate (IMHA) attended the ward every week.
- Patients' council meetings took place monthly and were facilitated by someone external to the clinic.
- Community meetings took place every month.

However:

- In September 2014 we found that seclusion records had not been filed in patient individual records promptly following episodes of seclusion. This remained a matter of concern. One patient's seclusion record had not been filed in his care records eight days after the seclusion episode.
- The Trust Seclusion policy was not fully compliant with the MHA CoP (2015) in terms of ending seclusion. In the section entitled "Seclusion procedure", on page 8 of the policy it was unclear that a doctor must be contacted before terminating an episode of seclusion. It states that the nurse in charge should consult with a doctor "wherever possible". In the section entitled "Termination of seclusion", on page 9 (paragraph 1) it is stated clearly that the nurse in charge must consult with a doctor before terminating an episode of seclusion. The Mental Health Act Code of Practice (MHA CoP 2015 26.144 pp306) specifically directs the nurse in charge to consult with a doctor without the caveat of "wherever possible". The consultation may take place on the telephone.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients could access an Independent Mental Capacity Advocate (IMCA) if they wished to do so.
- Staff we spoke to understood that mental capacity fluctuates and is decision specific.
- The Trust had policies in place to guide staff in understanding the Mental Capacity Act (MCA).
- There were no patients on DoLS (Deprivation of Liberty Safeguards).
- Staff we spoke with understood the Mental Capacity Act (MCA) and how mental capacity is decision specific and can fluctuate. The trust has policies to support staff in understanding the MCA.
- All patients had assessments of their capacity to consent to take medicine. These assessments had been completed by the RC.
- If patients lacked the capacity to make important decisions staff applied the 'best interests' legal framework and worked through the process.

However:

- No staff had attended MCA training.

Requires improvement

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

- There were a number of potential ligature points throughout the three wards and in the adjoining areas of the clinic. Ligature risks were present in bedrooms, toilets, bathrooms, and on some windows in communal areas. The Trust had documented all the ligature risks fully on the environmental ligature risk assessment. There was a ligature risk action plan in place with detailed strategies to reduce or mitigate any risks by way of risk assessment and judicious use of observations. However, there was no time frame for completion of the work indicated on the action plan.
- The physical layout of the wards meant there were not clear lines of sight. The fact that the configuration of the unit was circular meant that corridors curved so it was not possible to see very far without physically moving and following the curve of the corridor. This meant that staff would have to be quite close to a patient if performing line-of-sight observations. It would be difficult to perform unobtrusive line-of-sight observations and this may potentially lead to conflict with the patient if they feel watched.
- The corridors on the ward were not wide enough for three people to walk side by side. This meant that if staff were re-locating a patient under physical restraint from one area to another, they would not be able to do so in a face forward manner. Staff would have to manoeuvre side-ways with a potentially resistive patient. This would increase the potential risk of injury from trips and falls to all parties.
- The seclusion room had no natural light source. Natural light has been linked to improved mood.
- The security specifications regarding fencing, environmental searches and access to the clinic met the National Minimum Standards for General Adult Services in Psychiatric Care Units (PICU) and Low Secure Environments (Department of Health 2002), and the Royal College of Psychiatrists Standards for Low Secure Services (2012).
- A small room close to the reception area of the building was used to conduct personal searches of patients when they return from Section 17 leave. The room provided privacy and dignity for patients during the search process. It also served to confine any potential risk items to this room rather than within clinical areas.
- Long Term Segregation (LTS) was not used. There were no suitable facilities at the Gerry Simon Clinic to support the implementation of LTS.
- Patients' bedrooms had anti-barricade doors. This meant that patients would not be able to barricade themselves in their rooms and isolate themselves from the support of staff to help them stay safe.
- Three sets of ligature cutters were available at strategic points around the clinic. The ward manager was aware of the manufacturer's recommendations for maintenance of the ligature cutters and the sharpening schedule.
- The blanket restrictions in place are in relation to items which cannot be taken into the clinic and based on risk.
- All relevant information to support caring for patients was stored securely in the nursing office.
- Patients could personalise their bedrooms to reflect their tastes and preferences.
- The dining room furniture on Willow ward was fixed to the floor. This meant that the risk of anyone using this furniture as a weapon was negated.
- The clinic was clean. Cleaning records were up to date and displayed on the wards' walls.
- There was a bright, clean and cheerful staff-room away from patient areas. Staff could store food in a fridge-freezer and heat it in a microwave on meal breaks.
- A disused, lockable store cupboard was used for staff to securely store their coats and personal belongings.
- Medicines were safely stored and safely managed.
- All Section 58 (consent to treatment) forms were up to date and correctly filled in. Prescription charts reflected what was on the Section 58 forms. Audits were carried out by night staff to identify any missing signatures on medicine charts.
- Records showed daily checks of medicine fridge temperatures and clinic room temperatures being recorded. All temperatures were within safe limits for the storage of medicines.
- Alcohol based hand gel was available for use in staff areas.

Requires improvement

Are services safe?

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

- Clinical waste was managed and disposed of safely. Sharps such as syringes were disposed of in yellow clinical waste containers. These containers were not over-filled.
- All emergency equipment was present and regularly checked. All emergency equipment and medicine was in date.
- Care records were stored securely in the nursing office.
- Rooms for visits with adults were available in the shared space out of the secure clinical area. These rooms had to be pre-booked.
- Rooms suitable for child visits were available in the shared space out of the secure area. These rooms had to be pre-booked.
- All patients and staff we spoke with told us they felt safe in the clinic.
- The furniture in the de-escalation suite was worn and badly torn. This could potentially be an infection control risk as the sponge padding is exposed.
- There were unattractive, large brown water stains on ceilings around some of the sky-light windows.

Safe staffing

- Staffing levels at the Gerry Simon clinic were set by senior managers in the Trust in conjunction with the ward manager. The ward manager could not tell us if any safer staffing tool or model had been used to inform this process. Staffing levels across all three wards was three registered nurses and five support workers on the early shift which started at 7am and finished at 2pm. Three registered nurses and five support workers on the late shift which started at 1pm and finished at 8pm. An additional support worker works a 'twilight' shift which starts at 5pm and finishes at 12 midnight. In addition to these staff, there was an activities lead who was a registered nurse working from 9am until 5pm from Monday to Friday. The night shift started at 7:30pm and finished at 7:30am. Staffing on the night shift was two registered nurses and four support workers.
- Staffing levels mostly reflected what the planned staffing establishment should be. Any unfilled vacancies were due to short notice sickness absence, or increased enhanced observations where it had not been possible to recruit all the additional staff requested.
- There were 2.5 vacancies for full time registered nurses at the Gerry Simon clinic and 5.5 vacancies for full time support workers. These posts had been advertised but had not yet been recruited into.
- In the time period 1 April 2015 to 30 June 2015, a total of 368 shifts with vacancies were filled with temporary staff. This equates to an average of 1.3 shifts in a 24 hour period having a vacancy. In the same time period, a total of 51 shifts with vacancies were not filled as there were no staff available to cover them. This equates to an average of 17 shifts in a calendar month potentially affected by low staff numbers. There had been two incidents reported and recorded where the ward was short staffed in the time period April 1 2015 to November 16 2015.
- Temporary staff were used to fill vacant shifts. The group of temporary staff used were used regularly on the wards. These staff were preferentially used on the ward to promote consistency of care provided. Most temporary staff were from the nurse Bank at the hospital. Many of the Bank staff used were also permanent staff at the Gerry Simon Clinic. Agency staff were used rarely.
- Temporary staff were provided with an induction to the wards to orientate themselves to the environment. The induction also made them aware of security protocols and emergency procedures such as in response to fire.
- Sickness rates for staff were 12.9%.
- The staff team at the Gerry Simon clinic were a long standing team. Most of the team had worked together for a number of years. There had been one staff member who had left the clinic in the past 12 months.
- The ward manager told us it can be difficult to ensure all shifts are staffed with the appropriate gender ratio of staff to uphold patients' privacy and dignity. There were more female staff working on the wards than male staff.
- It was rare for low staffing levels to affect Section 17 leave or activities. If Section 17 leave was ever affected, priority was given to leave for healthcare purposes such as the GP or the dentist.
- Most staff were up to date with most of the mandatory training. The percentage of staff up to date with this training was 92% which equates to 34 out of 37 staff eligible for the training. The Trust was committed to increasing the percentage of staff being up to date with mandatory training to 95% by December 2015.
- Activities were re-scheduled to take place at an alternative time in the day rather than cancelled if staffing levels were low.

Assessing and managing risk to patients and staff

Requires improvement

Are services safe?

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

- All staff had personal, electronic alarms. The alarm was carried by individual staff members and fixed to their person. If an alarm was sounded the personal alarm would display the precise location of an incident by way of an LED panel on the top of the alarm.
- The alarm system was highlighted on the Trust risk register as not working effectively at the Heath Lane site. The time taken for the alarm to sound following being activated was felt to be too long (10 seconds if the button was depressed and 20 seconds if the cord was pulled).The Trust had listed on the risk register that they would contact the manufacturer to request that they review the system and improve its effectiveness. No time frame was provided regarding the completion of this work.
- There was a Security Protocol document which provided information for staff on all aspects of physical security and procedural security. A small room close to the reception area of the building was used to conduct personal searches of patients when they return from Section 17 leave. The room provided privacy and dignity for patients during the search process. It also served to confine any potential risk items to this room rather than within clinical areas. Blanket restrictions were based on risk and in place in relation to items which cannot be taken into the clinic.
- All patients' had comprehensive risk assessments and risk management plans. The Gerry Simon Clinic was engaged in a CQUIN which was about collaborative risk assessment and risk management.
- Psychologists assessed patients' risks in collaboration with patients using HCR-20 v3 (Historical, Clinical, Risk management version 3) easy-read, accessible format, recognised screening tools, for example, Risk of Sexual Violence Protocol (RSVP) and the Northgate Fire Setting Risk Assessment.
- Nursing staff assessed patients' risks using the Sainsbury risk assessment tool.
- Risk management plans were current and up to date. There was evidence of patient participation in developing these plans. Risk management plans follow a PBS model.
- Section 17 leave protocols and Section 17 leave plans were in easy-read accessible format.
- Behavioural plans and relapse prevention plans were in easy-read, accessible format.
- All patients had a Person Centred Physical Intervention Protocol. This was a plan which had been created in collaboration with the patient. The plan addressed how the patient's risks should be managed if staff had to implement physical interventions (restraint).
- Care plans were current and most have been evaluated within the time frame indicated on them. Some care plans had not been evaluated in the time frame indicated on the document. Care plans were available in easy-read accessible format.
- Joint working with patients was demonstrated in the care records. Risk assessments and risk management plans were available in easy-read, accessible format.
- Risk management plans followed a positive behaviour support model. This was aligned with the MHA Code of Practice (2015) and 'Positive and Safe' (Department of Health 2014).
- Psychologists provided tailored therapy for patients with a history of violent offending. This therapeutic programme was the 'Life Minus Violence Programme'.
- Trust data for the time period January 1 2015 to June 30 2015 demonstrated that physical restraint had been used on 21 occasions. This equates to an average of 3.5 times in a calendar month.
- The incidents of restraint involved nine different patients. This equates to an average of 2.3 incidents of physical restraint per patient restrained in the six month period reviewed.
- There was one recorded and reported incident of a patient being in the prone position during a physical restraint. We reviewed this incident with the ward manager.
- Staff knew how to implement physical interventions and seclusion safely.
- Seclusion was used rarely. Data supplied by the Trust showed that seclusion had been used on eight occasions in the time period January 1 2015 to November 16 2015. This equates to an average of 1.3 episodes of seclusion use per month in a 10.5 month time period. The incident reporting forms completed for these seclusion episodes clearly showed that all less restrictive interventions options had been implemented before resorting to seclusion. Some of the options recorded for less restrictive interventions being 1:1 time with staff, verbal de-escalation, distraction, physical restraint and PRN (Pro re nata – as required) medicine.
- Seclusion episodes were of short duration. They lasted for three hours or less.

Requires improvement

Are services safe?

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

- Trust data reflected that nine incidents of physical restraint had been recorded and reported without identifying which patients had been involved.
- Incident reporting forms recorded risk plans being devised in collaboration with involved patients following any incidents of violence or aggression.
- Incident reporting forms recorded whether any Safeguarding referrals had been made as a consequence of any risk incidents.
- Rapid tranquillisation had not been used in the past 12 months.
- There was a comfortable and safe de-escalation suite which was the preferred option for de-escalating disturbed behaviour at the Gerry Simon Clinic.
- The Modified Early Warning Score tool (MEWS) was in use to monitor patients' physical health following any incident where a patient had been subject to physical intervention.
- Patients' often complex physical health needs were met and monitored well. Patients were given physical health checks weekly by ward staff. Care plans contained detailed information about the care required for physical health needs. Those with issues around weight gain were engaged in health promotion regarding diet and lifestyle changes.

Track record on safety

- There had been no serious incidents in the 12 months prior to our inspection.
- There had been no 'never-events' in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

- Staff knew how to report and record risk incidents and near misses.
- All 179 risk incidents recorded and reported in the time period April 1 2015 to November 16 2015 were graded as 'no-harm' or 'low-harm'. This means that the severity of harm done was such that nobody involved required medical treatment. Measures implemented to mitigate these risk incidents tended to be increased levels of observation of the involved patient.
- Staff knew how to raise Safeguarding alerts. The means to do this were embedded in the incident reporting form.
- A Safeguarding incident was disclosed to us by a patient on the day we inspected the service. Staff and senior managers followed all the correct procedures to ensure the safety and well-being of the involved patient. The affected patient was provided with support from the ward manager, the senior psychologist, the nursing team, the Service Manager and the Director of Learning Disability forensic services at various stages of the process.
- Learning lessons from adverse events was demonstrated through a 'Lessons Learned' folder. The folder contained information about adverse incidents which had occurred throughout the Trust as well as locally. There was also information regarding any changes or outcomes as result of the lesson learned. An example of this being confusion having arisen in another service in the Trust around the terms and conditions of a patient's Section 17 leave. Changes were recommended regarding the manner in which such terms and conditions are documented.
- An incident involving a breach of confidentiality had led to learning which was shared with staff via an email.

Are services effective?

Good

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

- Patients care and treatment was aligned with relevant NICE guidance, the Mental Health Act Code of Practice (MHA CoP) (2015), Transforming Care (NHS England 2015) and the British Institute of Learning Disabilities (BILD).
- Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice using recognised tools and models.
- Patients' nutrition and hydration needs were assessed on admission using the MUST Malnutrition Universal Screening Tool.
- Potential infection risks were assessed on admission using an infection prevention and control risk assessment.
- Potential pressure sore areas were assessed using the Waterlow pressure sore prevention and treatment assessment tool.
- Patients were registered with a local dentist and attend regularly for check-ups and any treatment needed.
- Patients had a CPA every three months. Any unmet needs were identified at the CPA and are then addressed through care plans. We observed a CPA meeting and found it to be thorough with consideration given to all aspects of care and treatment. The patient and his carer were fully involved. Risk incidents the patient may have been involved in were rigorously explored. Medicine prescriptions were thoroughly reviewed. There was achievable goal setting towards recovery. There was an appropriate focus on discharge planning. The patient and his carer attended the CPA meeting. The carer was physically disabled and the team went to great lengths to ensure that he was comfortable and that his needs were met. We were impressed by the inclusive nature of the meeting which took the views of the patient and his carer into account.
- All patients had been assessed for their capacity to consent to treatment and all were appropriately considered to be consenting or not consenting to treatment.
- All Mental Health Act (MHA) and Mental Capacity Act (MCA) documentation was current and legal.
- Patients' care records were divided into two paper files as well as the electronic system. One paper file contained all the records generated by the medical staff and the other all the records generated by nursing staff and allied health professionals (psychologists, speech and language therapists, occupational therapists, social workers and activities staff). The electronic system contained electronic versions of some of the assessment or screening tools used. These could be filled in electronically and then printed and filed in the relevant section of the paper files.
- Outcomes for patients were measured using the Health of the Nation Outcome Score- Secure tool (HoNOS Secure).
- Patients and staff used the 'My Shared Pathway' document. This document contains specific details of the patient's individual goals towards Recovery and discharge.
- Patients used My Health Book which provided information about their health and how they can improve their health.
- Patients used a document called 'Learning about Myself'. The document guided them through structured questions about issues such as Section 17 leave.
- Ward staff had responsibility for various audits in the clinical area. For example, the senior psychologist had recently audited the consent to treatment paperwork; the Band 6 nurses audited the care records; the night nursing staff audited the medicine charts; a support worker audited compliance with hand-hygiene training.
- Concordance with relevant NICE guidance was audited by the MDT and the 'Positive Development Group'.
- Benchmarking against NICE guidelines took place and had identifiable outcomes for the service.
- Medicine prescriptions were reviewed by the MDT and the rationale for continuing, discontinuing or altering medicines prescribed was fully documented in the care records.

Best practice in treatment and care

- The Gerry Simon clinic participated in the Quality Network for Forensic Mental Health Services and was in the top 40 of rated participating organisations.
- Patients collaborated with psychologists in assessing and managing their risks. This was pilot study and it would be interesting to see if this had an effect on risk behaviour and related risk incidents.
- Patients attended and participated in staff training. Feedback received showed that this led to learning for the staff and for the patients.

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- Smoking cessation support was available for patients if they choose to give up smoking.
- Patients' physical health and well-being was regularly monitored and health promoting activities were well supported.
- The Clinical Commissioning Group (CCG) had agreed Commissioning for Quality and Innovation with the clinic. These were for the provision of weekly physical health checks and related health promoting activities, and collaborative risk assessment and risk management planning.
- Patients were registered with a local GP who provides them with an annual health check. Staff at the Gerry Simon clinic monitor patients physical health and well-being regularly and carry out any ongoing care required.
- Psychologists were based at the clinic. They provided one to one therapy for individual patients as well as various group therapies. The group therapies were 'Denial of Sexual Offences Group', 'Sex Offender Treatment Group' and 'Good Thinking Skills Group'. All the patients we spoke with told us they get a lot out of the psychology sessions they attend
- Psychologists used additional specific, recognised screening tools. These were the Risk of Sexual Violence Protocol (RSVP) and the Northgate Fire Setting Risk Assessment.
- Psychologists also provided tailored therapy for patients with a history of violent offending. This therapeutic programme was the 'Life Minus Violence Programme'.
- The speech and language therapist (SALT) worked as part of a team of three SALTs and communication assistants. The team worked to the guidelines laid down by The Royal College of Speech and Language Therapists. Patients were screened for dysphagia (difficulties with swallowing) by nursing staff using a screening tool devised by the SALT team. If the assessment highlighted any issues then nursing staff would refer the patient to the SALT team. The SALT team would respond to referrals within 10 working days.
- The SALT team contributed to assessing and care planning for any needs around communication. The SALT team were developing 'Communication Passports' for all patients. These passports would be helpful if the patient needed to access other services where staff had limited knowledge of them.
- Out of hours medical cover was provided within the Trust.
- Emergency medical care for patients was provided by Sandwell General Hospital.

Skilled staff to deliver care

- Staff attendance on Safeguarding Children Levels 2 and 3 was 86%. The Trust was committed to increasing the percentage of staff attending Safeguarding Children Levels 2 and 3 to 95% by December 2015.
- 89% (33 out of 37 staff) of staff were up to date with physical interventions (restraint) training. The training package used in the Trust was MAPA (Managing Actual and Potential Aggression). MAPA training does not include any techniques which could potentially cause pain or discomfort to encourage compliance.
- The ward manager had updated his staff on most of the relevant changes to the MHA CoP (2015) regarding the use of restraint and seclusion.
- All staff had access to supervision.
- All registered nurses at the Gerry Simon clinic were specialised learning disability nurses.
- The psychology team provided additional specialised training for nursing staff. The training they provided was about attachment theory, working with sex offenders with a learning disability, relational security, group facilitation skills, communication and risk assessment.
- The psychology team had developed some self-directed learning resources which staff could access on the Trust shared drive. There was also a resource list which directs staff to appropriate books and journals in the clinical library.
- The Model of Human Occupation Screening Tool was used by OTs to assess patients and measure outcomes from treatment. The Occupational Self-Assessment tool was also used by the OTs.
- The Trust had a policy and a standard operating procedure in place to guide registered nurses through the Nursing and Midwifery Council requirements for revalidation. Revalidation is the new way in which registered nurses and midwives will demonstrate their fitness to practice. The new revalidation process is in response to the findings of Sir Robert Francis in his inquiry into patient care at Mid-Staffordshire NHS FT.
- No staff had attended MCA training.
- Low numbers of staff had completed Safeguarding Adults Level 2 and Level 3 training. 70% of staff had attended Safeguarding Adults Level 2 training. This equates to 26 out of 37 staff eligible for the training. For Level 3 Safeguarding Adults training, 50% of staff had

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attended the training. This equates to 7 out of 14 staff eligible for the training. The Trust were committed to increasing the percentage of staff attending Safeguarding Adults Level 2 training to 95% by December 2015, and the percentage of staff attending Safeguarding Adults Level 3 training to 95% by December 2016.

Multi-disciplinary and inter-agency team work

- Assessments in care records were multidisciplinary in approach. Patients' care records showed that there was consistent multidisciplinary team (MDT) working taking place. Care plans always demonstrated input from a variety of professionals and were regularly reviewed by the MDT. All patients we spoke with told us they were supported by a number of different professionals on the ward. Six patients we spoke with told us they had contributed to their care plans and had signed them and been provided with copies for their own records. One patient told us they could not recall signing their care plan.
- The multidisciplinary team worked well together. Each profession represented contributed towards patients' care and treatment from their professional perspective.
- The Speech and Language Therapy team were not based on the ward and rarely had the capacity to attend the MDT or CPAs. They would prepare reports which contribute to these meetings.
- There was a consultant psychiatrist who was the Responsible Clinician for all patients at the Gerry Simon clinic. He was also the associate clinical director for the learning disability division in the Trust.
- The consultant was supported by a locum specialist registrar. The permanent post will be advertised in the near future.
- There was no social worker. The social worker had left the service four days before our visit and had not yet been replaced. In the CPA meeting we observed there were issues highlighted which required social work input. The MDT had to consider sourcing some social work support from elsewhere in the Trust. This could potentially delay progress for the patient's care.
- Information relevant to each patient was shared with other teams as appropriate and in a timely manner.
- Patients were partners with the MDT in directing their care.
- Occupational therapy (OT) was currently provided by a Band 5 occupational therapist. A band 6 occupational therapist is to be recruited. The Band 5 OT was receiving clinical supervision monthly from a Band 6 OT in another service in the Trust.
- There were good links with other agencies. The RC liaised with the CCG regarding the admission of patients from medium secure facilities to ensure that any potential admissions were timely and not excessively delayed. The RC ensured that links are maintained with local services. This was so that any patients whose community placement was breaking down, or failing, were quickly identified. This meant that plans could be put in place regarding re-admission to the service, or some other alternative care package could be implemented.
- The MDT linked in with community services such as substance misuse services, to share skills and to collaborate in discharge planning for patients.
- All patients were registered with a local GP.
- Dental care was provided by a local dentist.

Adherence to the MHA and the MHA Code of Practice

- We found all section 17 leave forms had been signed by patients and the patients with whom we spoke told us that they had copies of their leave forms.
- We saw records that hearings and tribunals took place as per patients' rights and wishes. We saw that Second Opinion Appointed Doctors (SOADs) had reviewed care as required by the MHA.
- Patients' had their Section 132 Rights presented to them on a regular basis and it was documented by staff whether they had understood them.
- We were told that an Independent Mental Health Advocate (IMHA) attends the ward every week.
- Patients' Council meetings took place monthly and were facilitated by someone external to the clinic.
- Community meetings took place every month.
- In September 2014 we found that seclusion records had not been filed in patient individual records promptly following episodes of seclusion. This remained a matter of concern. One patient's seclusion record had not been filed in his care records eight days after the seclusion episode.
- The Trust Seclusion policy was not fully compliant with the MHA CoP (2015) in terms of ending seclusion. In the section entitled "Seclusion procedure", on page 8 of the policy it was unclear that a doctor must be contacted

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before terminating an episode of seclusion. It states that the nurse in charge should consult with a doctor "wherever possible". In the section entitled "Termination of seclusion", on page 9 (paragraph 1) it is stated clearly that the nurse in charge must consult with a doctor before terminating an episode of seclusion. The MHA CoP 2015 26.144 pp306 specifically directs the nurse in charge to consult with a doctor without the caveat of "wherever possible". The consultation may take place on the telephone.

Good practice in applying the MCA

- There were no patients on DoLS (Deprivation of Liberty Safeguards).
- All patients had assessments of their capacity to consent to take medicine. These assessments had been completed by the RC.
- If patients lacked the capacity to make important decisions staff applied the 'best interests' legal framework and worked through the process.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff spoke to us in respectful terms about patients.
- We experienced staff being honest and transparent with us. We saw staff act with integrity in response to issues we raised with them. We saw staff treat patients with compassion and kindness when they were upset or disturbed. We saw staff being mindful of patients' dignity and respect when sometimes the patient was too upset to be able to maintain this for themselves.
- Everything at the Gerry Simon clinic was directed at promoting independence at the patient's own pace. This was reflected in the detail of care plans and in the 'My Shared Pathway' document.
- Patients could personalise their bedrooms to their own tastes and preference.
- One patient told us that a member of staff comes in on his day off to take him on Section 17 leave to visit the patient's family.

The involvement of people in the care they receive

- Patients and their families or carers were involved in making choices about their care. We observed a CPA meeting where the patient and his carer were consulted and provided with choices. Their views were accorded respect and significance.
- Patients were partners with the MDT in directing their care. Patients and staff told us this and we observed this working in practice.
- Six out of seven of the patients we spoke to told us they had had input to their care plans and had signed them. We saw evidence of this in the care records.
- Patients jointly assessed their own risks with psychologists using the HCR 20 v3 assessment tool in easy-read (accessible) format.
- Patients participated in a training day alongside staff. The training was about risks, risk assessment and risk management. There was focus on the importance of relational security. Patients fed back that they had enjoyed the training day and participating in the workshops and group work. They said it had improved their understanding of their own risks and the influence of factors such as alcohol or illicit substances on risk behaviours. This work is linked to the CQUIN on collaborative risk assessment and risk management planning currently in place at the clinic.
- Patients could attend the monthly Patients' Council to raise any concerns or discuss any ideas they have about changes to the clinic. We observed a Patients' Council meeting where the patients said they wanted a suggestion box on the ward for use by patients and staff. This was approved and a request was made for the maintenance department to carry out the necessary work.

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

- Referrals were accepted from a variety of settings in the community and within forensic services.
- The referral process could take up to six weeks from the point of referral.
- Referrals were discussed by a panel made up of the consultant psychiatrist, a member of the nursing team and a psychologist. This panel would decide whether a patient would benefit from admission to the service.
- In the time period December 1 2014 and May 31 2015 there was 97% bed occupancy excluding leave days. This was the highest bed occupancy rate over the same time period compared to other inpatient wards at the trust.
- In the time period December 1 2014 and May 31 2015 2% of discharges were delayed. The maximum delay to a discharge was 49 days.
- There was a focus on discharge from the outset of admission. All care plans were devised in such a way as to promote independence at the patient's own pace while working towards the goal of discharge to a setting of less security.
- "Shadow leave" was used to positive risk take with patients. Shadow leave was where staff will follow a patient on Section 17 leave at a distance. In this way the staff could monitor the patient's ability to stay safe when out on leave and report on it for consideration by the MDT. Equally, the staff could step in if the leave is not going well and safety is becoming compromised.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients were provided with a folder on admission with all the relevant information about the Gerry Simon clinic.
- A recently appointed gym instructor had made significant progress in motivating patients to participate in gym activities. Patients have demonstrated weight loss as a consequence of changes to diet and lifestyle.
- There were different activity rooms; there were art and craft spaces, a practice kitchen for preparing meals and snacks, a large hall for ball games and other group activities, a well-equipped gym and areas where academic study and computer use can take place.
- Twenty five hours plus of activities were provided for all patients. There were a wide range of educational and recreational activities provided as well as activities to improve skills in the activities of daily living. For example, budgeting when purchasing food, awareness of good food hygiene standards, awareness of food storage requirements, following cooking instructions and recipes, using kitchen equipment safely and cleaning up and putting everything away afterwards.
- The Patients' Council challenged a number of local initiatives, for example, access to smoking in the evenings at the clinic. It was agreed that patients may only smoke in the designated shelter on the secure courtyard. In addition, all patients can smoke when on Section 17 leave.
- Patients had been given a £4,000 sum to invest in a business, printing patient art work on mugs and T-shirts to sell. The profit will go to improving amenities for the patients in the service. There were examples of patient drawings in the clinic, for example, pencil drawings of wild-life on display around the clinic and it is these art works which will be reproduced on the mugs and T-shirts.
- Patients had access to a cordless ward telephone which was supervised or un-supervised in their bedrooms, if risk assessment allows.

Meeting the needs of all people who use the service

- Local spiritual leaders provided spiritual support to patients. Patients were supported to attend spiritual gatherings, such as church or mosque, if they wished to do so.
- Dietary requirements such as Halal or Kosher meals could be catered for.
- The clinic was on the ground floor and had adapted facilities to accommodate people with physical disabilities and people who used wheel-chairs. The narrow corridors in the building would make manoeuvring a wheel-chair in the environment challenging without some assistance. There were no wheel-chair users residing at the clinic on the day of our visit.
- Most patients told us that they had Section 17 leave but could not always take it. It was unclear from discussions and care records why this was the case.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Good

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

- Patients had a number of ways in which they could make complaints, comments or compliments. There had been three formal complaints logged with the trust. Two of these had been upheld. We saw a formal complaint which was dated May 6 2015 from a patient's relative. The response to the complaint was dated 8 June 2015, which meant that the process had exceeded the 28 days target the Trust had set itself for resolution of complaints. Despite the response being overdue, the response was detailed, polite and informative. It provided advice for the relative regarding what they could do if they were dis-satisfied with the response from the Trust. Staff and patients told us that complaints were usually resolved at ward level.
- There had been one compliment logged with the Trust.
- Patients were supported by all MDT staff if they wanted to raise a concern. We observed this in practice on the day of our inspection.
- Patients could raise any complaints or concerns in the Patient Council. Outcomes from these were fed back to the Patient Council.

Are services well-led?

Good

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 were able to tell us about the Trust values of honesty and transparency, integrity, empowerment, compassion and kindness, dignity and respect.
- The Trust vision was to work closely with the local community to improve health and wellbeing for all who live in the local area. We heard how staff at the clinic had plans to create a community learning disability forensic team to provide better support for patients when they are discharged to the community. This would improve outcomes for patients and reduce admissions to inpatient services.

Good governance

- Risk incidents were monitored locally through discussion at a dedicated meeting of senior staff. Staff were encouraged to attend. Risk incidents were also discussed at a Trust-wide risk and safety group. Any emerging themes or trends were identified and addressed through changes to practice or changes to individual patient's care plans.
- Key Performance Indicators were used to measure the "culture of care".
- Health of the nation outcome scales for secure settings was used to measure patients' progress.
- The use of restraint (physical, mechanical and chemical) was monitored through governance at the ward level and by senior management at the organisational level.
- Poor or variable staff performance was managed using the Trust capability policies and procedures. There were no staff being performance managed on the day of our inspection

Leadership, morale and staff engagement

- 95% of non-medical staff had up to date appraisals. This equates to 37 staff out of 39. 100% of medical staff were up to date with their appraisals. This equates to two doctors; the consultant and the registrar.
- Staff training and learning needs were identified through the Trust training matrix for mandatory training. Additional staff training and learning needs were identified through annual appraisals.
- Nursing staff had weekly reflective practice sessions which were facilitated by a psychologist. These sessions allowed nursing staff to explore any specific issues where they were having difficulties in meeting the needs of any individual patients. They also provided an opportunity for nursing staff to share examples of positive practice.
- The ward manager was a visible presence on the wards.
- There were regular team meetings and staff felt well supported by their manager and colleagues in the clinic. Staff mentioned good team work as one of the best things about their ward.
- The consultant and the senior psychologist provided visible leadership and support for staff and patients.
- Senior managers frequently visited the service and were well known to the staff and to the patients.
- Staff told us their morale was good. We observed staff to have good morale and to be cheerful and positive about their role.

Commitment to quality improvement and innovation

- Patients collaborated with psychologists in assessing and managing their risks. This was pilot study and it would be interesting to see if this had an effect on risk behaviour and related risk incidents.
- Patients attended and participated in staff training. Feedback received showed that this led to learning for the staff and for the patients.