KEMPLE VIEW

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

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

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

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

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

Summary of findings

Overall summary

We rated Kemple View as **outstanding** because:

- The service provided safe care. Safety systems were robust and comprehensive. The ward environments were safe and clean. There were enough nurses and doctors. Staff assessed and managed risk well. They were proactive in encouraging patients to manage their own risks. Relational security was very good. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. The use of restraint and seclusion had decreased since our previous inspection. There was a focus on openness, transparency and learning when things went wrong. There was a clear 'no blame' culture.
- There was a strong recovery focused ethos. Staff worked collaboratively with patients. They focused on helping patients to be in control of their lives and building their resilience so that they could regain a meaningful life.
- Staff developed truly holistic, recovery-oriented care plans informed by comprehensive assessments. They supported patients to take as much responsibility for developing their care plans as they could. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Patients had access to the full range of specialists required to meet their needs. Managers ensured that staff received training, supervision and appraisal. Continuous development was recognised as essential to high quality care. Staff were proactively supported to acquire new skills and share best practice. Staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare. They used technology to help ensure that care and treatment was co-ordinated with other services and providers.
- Staff encouraged and supported patients to use community facilities, reflecting the focus on appropriate behaviour and life in the wider community. The involvement of other organisations and the local community was integral to how they planned care and treatment. There was a clear culture of positive risk taking.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- There was a strong, person-centred culture. Putting patients at the centre of care, involving and empowering them was clearly embedded. Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively sought their feedback on the quality of care provided. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason. Patients were central to care delivery. Staff were proactive in understanding the needs of different groups, especially those who were vulnerable or had complex needs. There was high involvement and engagement with other organisations and the local community that ensured integrated care co-ordinated with other services.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. The leadership, management and governance assured delivery of high-quality and person-centred care, supported learning and innovation, and promoted an open and fair culture. Safety and quality was prioritised. The emphasis on patient involvement was evident across the hospital. Patients were involved in governance at all levels. There was a genuine commitment towards continual improvement and innovation, and a culture of collective responsibility. Staff were motivated to deliver change. Rigorous and constructive challenge was welcomed and seen as a way of holding services to account.

However:

- Staff on Oakwood were unsure where environmental risk assessments were stored.

Summary of findings

- Staff on Oakwood were not following the provider's process in relation to patients who were self-medicating.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	**Outstanding** ☆	Forensic care and treatment in conditions of low security.
Long stay or rehabilitation mental health wards for working-age adults	**Outstanding** ☆	Specialist forensic rehabilitation for patients stepping down from a higher level of security.

Summary of findings

Contents

Outstanding ☆

Kemple View

Services we looked at
Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to KEMPLE VIEW

Kemple View is an independent hospital that is part of the Priory Group. It is situated in Langho, near Blackburn, Lancashire. The hospital provides services for 90 men with mental health needs. Care and treatment is provided in four low secure wards and two rehabilitation wards.

Kemple View is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The registered manager is Margaret Mary Gallagher.

We inspected all six wards at Kemple View.

Arkwright is a 10 bedded forensic ward for older men.

Elmhurst is a 19 bedded forensic ward for men with challenging and complex mental health needs.

Kenton is an 11 bedded forensic ward for men undergoing a sexual management programme.

Wainwright is a 16 bedded forensic ward for men with personality disorder and dual mental health needs.

Hawthorn is a 15 bedded high dependency rehabilitation ward.

Oakwood is a 19 bedded longer term high dependency rehabilitation ward.

All wards have controlled access.

During this inspection, there were 90 men receiving care at Kemple View. All were detained under the Mental Health Act 1983.

The Care Quality Commission has inspected Kemple View on five previous occasions. The last comprehensive inspection of Kemple View was on 26-28 October 2015. The service was compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and was rated outstanding.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, two CQC inspectors, two CQC assistant inspectors, two CQC pharmacy inspectors, two specialist advisors with a background in mental health nursing, and two experts by experience, who are people with experience of using or caring for someone who uses similar services.

Why we carried out this inspection

We inspected this 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 the location.

Summary of this inspection

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 41 patients who were using the service
- spoke with the registered manager
- spoke with the ward manager or nurse in charge on each of the wards
- spoke with 12 other staff members including a doctor, nurses, an occupational therapist, a psychologist and a social worker
- received feedback about the service from three commissioners
- attended and observed one hand-over meeting and one multi-disciplinary meeting
- collected feedback from 21 patients using comment cards
- looked at 22 care and treatment records of patients and 22 prescription charts
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 41 patients who were using the service and we received feedback from 21 patients using comment cards.

Most patients had positive things to say about Kemple View. They reported that there were enough staff, and that the staff were supportive, respectful, kind and caring, and always listened.

They praised the facilities, such as using computers, the gym and music, and they told us that they had plenty of opportunity for activities away from the ward setting. They described the activities they took part in.

They were happy that their care and treatment was right for them and met their needs, and talked about making plans to move on. They said they felt safe.

Most said the food was good.

There were nine negative comments that related to maintenance, complaints, restrictions, therapy, leave and staff attitudes.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Outstanding 

We rated safe as **outstanding** because:

- Patients were protected by robust safety systems and a focus on openness, transparency and learning when things went wrong. They were protected from avoidable harm and abuse.
- There were comprehensive systems to keep people safe, which took account of current best practice. The whole team was engaged in reviewing and improving safety and safeguarding systems. Patients were at the centre of safeguarding and protection from discrimination. Leaders encouraged innovation to achieve sustained improvements in safety and continual reductions in harm.
- The wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. There was space for activities, and there were quiet areas. There were effective systems for maintaining safety and security.
- The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep patients safe from avoidable harm. There were effective handovers and shift changes.
- There was a highly proactive approach to assessing and managing risk that was embedded and recognised as the responsibility of all staff. Risk assessments of the environment were carried out regularly and there were clear action plans to address any issues. Staff assessed and managed risks to patients and themselves very well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. All staff had an excellent understanding of relational security.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. They used positive behaviour reinforcement to deal with potentially violent situations. There was a clear culture of least restrictive practice and positive risk taking. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. Staff contributed to the provider's restrictive interventions reduction programme. The use of restraint and seclusion had decreased since our previous inspection.
- Staff supported patients to be actively involved in managing their own risks. They were able to discuss risk effectively with patients. Staff and patients assessed and managed individual

risks together. The risk assessments were person-centred and proportionate. They were reviewed regularly, and staff recognised and responded appropriately to changes in risks to patients.

- Safeguarding was prioritised. There were clearly defined and embedded systems to keep patients safe from abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There was good engagement with the local safeguarding authority. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. The systems to manage and share the information needed to deliver effective care treatment and support were co-ordinated, provided real-time information, and supported integrated care for patients. Patients were able to transition seamlessly between services because there was advance planning and information sharing between teams. Innovative practice supported accurate and personalised information sharing.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff met good practice standards in relation to national guidance. They regularly reviewed the effects of medications on each patient's physical health. Compliance with medicines policy and procedure was routinely monitored and action plans always implemented promptly.
- The services had an excellent and sustained track record on safety. This was supported by accurate performance information. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. There was ongoing, consistent progress towards a zero-harm culture.
- There was a genuinely open culture in which all safety concerns raised by staff and patients were highly valued as being integral to learning and improvement. Staff were open and transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses and ensured a robust picture of quality. Learning was based on a thorough analysis and investigation of things that had gone wrong. All staff were encouraged to participate in learning to improve safety as much as possible, including working with others and where relevant, participating in local, national, and international safety programmes. Opportunities to learn from external safety events were

Summary of this inspection

identified. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Patients were involved via the service user council attendance at clinical governance meetings.Learning from incidents was shared and acted on. Staff apologised and gave patients honest information and suitable support. There was a clear 'no blame' culture.

However:

- Staff on Oakwood were unsure where environmental risk assessments were stored.
- Staff on Oakwood were not following the provider's process in relation to patients who were self medicating.

Are services effective?

Outstanding ☆

We rated effective as **outstanding** because:

- Staff assessed patients' needs and delivered care and treatment in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. They took a truly holistic approach to assessing, planning and delivering care and treatment. Leaders actively encouraged the safe use of innovative approaches to care and how it was delivered, such as implementing new assessment tools and outcomes measures, and utilising research findings to make improvements.
- Staff thoroughly assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multi-disciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were highly personalised, holistic and recovery-oriented. Staff supported patients to take as much responsibility for developing their care plans as they could.
- Staff provided a wide range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Interventions were evidence-based and recovery focused. They included access to a comprehensive programme of psychological therapies, to support for self-care and development of everyday living skills, and to meaningful occupation. Patients were highly involved in developing their own treatment programmes.
- Staff took a proactive approach to health promotion and preventing ill health. They ensured that all patients had good access to physical healthcare and they supported patients to live healthier lives, including those who needed extra support. There were initiatives to improve physical health.

Summary of this inspection

- There was a strong recovery focused ethos. Care and treatment achieved excellent outcomes and promoted a good quality of life. All staff were actively engaged in activities to monitor and improve quality and outcomes. They used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care.
- Continuous development of staff skills, competence and knowledge was recognised as essential to high quality care. Managers proactively supported and encouraged staff to acquire new skills, use their transferable skills, and share best practice. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. There were a number of initiatives to promote staff wellbeing and retention.
- Staff understood the benefits of close working with allied health professionals. They were committed to working collaboratively. Staff from different disciplines worked together effectively to benefit patients and co-ordinate person-centred care. They supported each other to make sure patients had no gaps in their care. The ward teams had highly effective working relationships with other staff from services that would provide aftercare following the patient's discharge. They took a holistic approach and engaged with other services early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. They worked effectively with others to promote the best outcomes with a focus on recovery for patients subject to the Act. Managers made sure that staff could explain patients' rights to them. Patients detained under the Act understood and were empowered to exercise their rights.
- Staff supported patients to make decisions about their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

We rated caring as **outstanding** because:

Outstanding ☆

Summary of this inspection

- There was a strong, person-centred culture. Putting patients at the centre of the service, involving and empowering them was clearly embedded. Relationships between patients, relatives and staff were strong, caring and supportive. Staff were responsive, caring and enthusiastic about the patients' care and their progress. They valued and promoted positive relationships. They were committed to working with patients and empowering them to realise their potential. Patients felt fully involved in their care planning and review processes. They had regular opportunities to have their say in reviews of their care. There were several initiatives to support and improve patients' experience.
- Staff respected patients as individuals. They treated patients with compassion and kindness, and respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. They supported patients with their emotional and social needs, to enable them to manage their own health and care and to maintain their independence.
- Staff respected and valued patients as individuals. They empowered them as partners in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients' preferences were reflected in delivering care and treatment. They ensured that patients had easy access to independent advocates.
- There was a culture of shared decision making and patients were actively involved in all aspects of service development.
- Staff supported patients to maintain and develop their relationships with the people close to them, their social networks and community. They informed and involved families and carers appropriately.
- Staff actively promoted advance decision making so that all staff could understand how the patient would like to be cared for when they were not well.

Are services responsive?

Outstanding ☆

We rated responsive as **outstanding** because:

- Services were tailored to meet the needs of individual patients and were delivered in ways that ensured flexibility, informed choice and continuity of care.
- Patients were central to care delivery. Staff had extensive knowledge of patients care needs and focused on helping them to be in control of their lives and build their resilience so that they could regain a meaningful life. They took innovative

approaches to providing cohesive person-centred care that involved other service providers. Staff were encouraging and highly motivational in the support they provided. They were warm and friendly towards patients and there were extremely high levels of interaction between them. Patients were involved in the design and delivery of services and day-to-day decision-making. Care pathways were clear and patients' individual needs and preferences were central to the planning and delivery of personalised care.

- There was a clear strategy for involving relatives and carers, and staff actively sought carers' views. They supported patients to maintain contact with their families and carers. Patients could use technology to keep in touch with the people close to them. Patients had also facilitated a family and carers' open day. Carers were involved with a range of issues, including training. This supported carers and patients to form wide support networks.
- Staff encouraged former patients to share their recovery journey with patients who were still in hospital so that they received support from their peers.
- Staff took a positive approach to understanding patients' diverse needs and deliver care in a way that was accessible and promoted equality. They were proactive in understanding the needs of different groups, especially those who were vulnerable or had complex needs. They met the individual needs of all patients who used the service, including those with protected characteristics. Staff helped patients with communication, advocacy and social, cultural and spiritual support.
- There was a strong focus on appropriate behaviours and life in the wider community. Patients were enabled to participate in activities in the local community so that they could exercise their right to be a citizen as independently as they were able to. There was high involvement and engagement with other organisations and the local community that ensured integrated care co-ordinated with other services.
- Staff planned and managed discharge well. Discharge planning took patients individual needs, circumstances and ongoing care arrangements into account. Staff liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Summary of this inspection

- Feedback from patients was taken seriously. Patients felt able to talk to staff or managers whenever they needed to. They knew that they would be listened to and their concerns addressed.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. Complaints were seen as an opportunity to understand patients' perspective and improve practice. Patients were involved in reviewing complaints via the service user council. Learning from reviews informed change and improvements, and was shared with other services.

Are services well-led?

Outstanding 

We rated well-led as **outstanding** because:

- The leadership, management and governance assured and drove delivery of high-quality and person-centred care, supported learning and innovation, and promoted an open and fair culture. Safety and quality were prioritised.
- There was a highly positive, transparent and person-centred culture across the location. The leadership was inspiring and proactive in guiding others to achieve successful outcomes for patients, and this clear commitment was replicated throughout the hospital site.
- There was a huge commitment to recovery at all levels, and a great emphasis on supporting patients to develop and build the skills they needed to live independently in the community.
- Leaders had the skills, knowledge and experience to perform their roles, and had a thorough understanding of the services they managed. They were inspiring and motivational to staff. They were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. They described a shared recovery-focused vision.
- Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. They encouraged and valued co-operative, supportive relationships. Staff satisfaction was high. Staff felt respected, supported and valued. They were proud of the organisation as a place to work and spoke highly of the culture. They reported

Summary of this inspection

that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Audit processes impacted in a positive way. Different levels of governance interlinked effectively. Patients were involved in governance at all levels.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.
- There was a genuine commitment towards continual improvement and innovation, and a culture of collective responsibility. Staff engaged actively in local and national quality improvement activities.
- Feedback from surveys, quality matters, and patient-reported outcomes were actively used to inform and prioritise improvements in patient experience and care. The service was proactive in capturing and responding to patients' concerns and complaints. Staff were creative in involving patients in all aspects of the service.

Detailed findings from this inspection

Mental Health Act responsibilities

Training in the Mental Health Act (MHA) was mandatory, and 88% of staff had had training.

Managers supported staff to understand and meet the standards in the Mental Health Act Code of Practice. They understood their roles and responsibilities, and managers made sure that staff could explain patients' rights to them. They did this every month. They explained in ways that patients could understand and recorded that they had done it. They repeated the information when necessary. Patients understood their rights under the Act and they were empowered to exercise them. Some patients had exercised their right to appeal to the mental health tribunal (MHT) and/or the hospital managers. When necessary, the service had made referrals to the MHT. Decisions were recorded and patients were informed about decisions.

Staff worked effectively with others to promote the best outcomes for people subject to the MHA, with a focus on recovery.

Where patients were subject to the Mental Health Act, their rights were protected and staff complied with the associated Code of Practice. Adherence to the MHA and Code of Practice was good.

All treatment was given under appropriate legal authority and the relevant certificates were in place, along with review of treatment documentation for patients assessed as not being capable of understanding the nature, purpose and likely effects of the treatment. The responsible clinician had noted the patients' capacity to consent to treatment at the most recent authorisation. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff had good access to administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff knew who the Mental Health Act administrators were.

There were relevant policies and procedures that reflected the most recent guidance. Staff had easy access to the policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. There was an independent mental health advocate who provided support to patients on request.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted. All patients had section 17 leave, either in groups or individual.

Staff stored copies of patients' detention papers and associated records, such as section 17 leave forms, correctly. Staff had followed the procedures for renewing detention and the criteria for renewal had been met. The records were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely.

Care plans referred to identified section 117 aftercare services for patients who had been subject to section 3 or part 3 powers authorising admission to hospital.

Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly, and there was evidence of learning from those audits. An audit had been completed for each patient in September 2018.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act (MCA) was mandatory, and 95% of staff had had training.

Staff understood and complied with the requirements of the MCA and the five statutory principles.

There was a policy on the Mental Capacity Act, including the Deprivation of Liberty Safeguards. Staff had easy access to the policy and they understood it. They knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards. The social work team provided guidance.

Detailed findings from this inspection

Consent to care and treatment was obtained in line with legislation and guidance. Staff assumed that patients had capacity and they supported patients to make decisions about their care for themselves. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

Staff understood that capacity fluctuated and that patients may have capacity to consent to some things but not others. They gave patients every possible assistance to make a specific decision for themselves before they considered that the patient might lack the mental capacity to make it.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Practices around consent and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.

Use of restraint was understood and monitored. Less restrictive options were used wherever possible.

Deprivation of liberty was recognised and only occurred when it was in a patient's best interests, was a proportionate response to the risk and seriousness of harm to the patient, and there was no less restrictive option to ensure the patient received the necessary care and treatment.

There were no patients subject to the Deprivation of Liberty Safeguards and there were no pending applications.

The service monitored adherence to the Mental Capacity Act. They audited the application of the Act and took action on any learning that resulted from it.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Long stay or rehabilitation mental health wards for working age adults	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Forensic inpatient or secure wards

Safe	Outstanding ☆
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are forensic inpatient or secure wards safe?

Outstanding ☆

Safe and clean environment

All the wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

There were spacious communal rooms, activity areas and kitchens. There was a lounge and separate dining room that patients had access to throughout the day. Patients were able to make their own drinks and snacks whenever they wanted. There were further quiet rooms and visiting rooms. Cleaning records were complete and up-to-date. The furniture appeared comfortable and most was in good order.

Patients all had their own en-suite bedrooms. The bedrooms were spacious and had a lockable space for personal items. There were nurse call alarms next to each bed. There were additional showers and bathrooms. Bathrooms were clean and tidy. Funding had been secured to refurbish the bathrooms on Elmhurst ward.

The service only admitted male patients, so all wards complied with Department of Health guidance on the elimination of mixed sex accommodation.

As part of the recovery programme, patients who were able to keep their own bedrooms clean were encouraged and supported to do so by staff.

The ward décor was bright and well maintained.

The ward managers told us that staff had worked with patients to look at what pictures they wanted on the ward instead of buying generic ones. Patients had identified local areas they liked, such as woodland and streams, and had taken photographs of them. The staff had then arranged to have the photographs transferred onto canvases, which were displayed around the ward.

The layout of the wards did not allow clear lines of sight throughout but risks were mitigated by using mirrors, observation and staff presence, staff awareness, care planning, individual risk assessments and levels of observation, and good relational security.

These measures ensured staff could monitor all areas of the wards. They carried out regular risk assessments of the care environment that included blind spots and external areas, and they knew about potential ligature anchor points and actions to mitigate risks to patients who might try to harm themselves. For example, bedrooms were fitted with anti-ligature wardrobes and fixtures and fittings, such as collapsible curtain rails.

There were red, amber and green rated floor maps displayed in the staff rooms that identified high risk areas at a glance, although they did not provide the level of detail the risk assessments did.

Staff had easy access to alarms and patients had easy access to nurse call systems. The ward doors were locked and staff, patients and visitors entered and left the wards via an airlock.

The door access system operated in conjunction with a key tracker system that blocked the exit if a key holder tried to leave before returning their keys. All staff understood the safe management of keys.

Forensic inpatient or secure wards

The low secure wards had a designated security nurse on each shift to oversee access, security and safety. The security nurse carried out hourly checks.

Staff had personal alarms to call for assistance if there was an emergency. The alarms were linked to a hospital wide system. There were designated staff on each shift who responded to incidents on other wards.

Security was grounded in staff knowledge and understanding of their patients. Relational security was well embedded. Staff understood the significance of building trust, setting and maintaining boundaries and understanding the patient group dynamic to ensure there was an appropriate balance between restriction and a caring environment.

All the wards had secure garden areas. There were written protocols on each ward for access to the garden areas. Patients' views had informed the protocols. Patients generally had unsupervised access during daylight hours, depending on individual risk assessment, which was reviewed if individual patients' risks or safety changed. Security checks were completed before the gardens were used, and randomly four times every hour after that. Patients who had appropriate leave could also access other outdoor areas across the site.

Two of the low secure wards had seclusion facilities. The seclusion rooms met the requirements of the Mental Health Act 1983 Code of Practice, although one did not have direct access to toilet facilities or to fresh air, which were located across the corridor. The provider had secured funding for the seclusion suite to be refurbished to address this.

There were low stimulus rooms on each ward in the low secure service, which were used to assist with de-escalation. Patients could use these rooms at any time and could leave them when they wanted to.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

The service provided locked storage for each patient to store any valuable possessions they had. Any banned items, such as cigarettes and lighters, were kept securely by staff.

The atmosphere on the wards was relaxed. Patients conversed openly with staff and the inspection team. They were comfortable in the presence of staff. Many of the patients were off the ward doing various individual and group activities with staff or on unescorted leave periods. None of the patients we spoke with complained of boredom.

In the entrance to the wards, there were notice boards with staff photos. There were also boards in the corridors that showed all the birthdays of staff and patients, activities they enjoyed and key dates for the month in an easy read visual format.

Safe staffing

There were enough nursing and medical staff, who knew the patients and received training to keep people safe from avoidable harm. Managers ensured each shift had appropriate numbers of staff with the right skills. Staffing ratios were in accordance with best practice guidance.

The wards operated to an agreed staffing ladder made up of qualified nurses and healthcare workers. The staffing ladder calculated the number of each discipline required to safely staff the ward for the number of current patients. Patients requiring escorts and constant nursing observation and engagement support sat outside the ladder and additional staff were brought in to fulfil those duties. Staffing was increased when required. Ward managers met with the director of clinical services every day to review staffing. Additional staff requirements were supported as clinical needs dictated so that patient care remained safe. Out of hours staffing needs were monitored by the site co-ordinator and staffing concerns could be escalated via the provider's established process, providing support as needed from senior managers and access to staff across the region.

Across the site there were no registered nurse vacancies and 18.9 nursing assistant vacancies out of 116 whole time equivalent posts.

From January to December 2018, the sickness rate was 2.4% across the hospital site.

When necessary, managers used bank nursing staff to maintain safe staffing levels. There was a pool of bank staff who completed regular shifts. They could book shifts using a text system that had been developed internally. All bank staff completed a comprehensive induction prior to attending the wards. They were also offered training

opportunities, dedicated weekend training days, attendance at wellbeing events and clinical supervision to ensure they felt engaged as part of the staffing establishment.

There was a preferred supplier list of agency staff, which entailed strict agency worker competencies and governance arrangements. Agency staff would receive a local induction checklist and be supervised.

In the three months from October to December 2018, the following shifts had been filled by bank staff:

- Arkwright - 139
- Elmhurst ward - 140
- Kenton ward - 59
- Wainwright - 177

No shifts were unfilled. No agency staff had been used.

A qualified nurse was present in communal areas of the ward at all times.

Staffing levels allowed patients to have regular one-to-one time with their named nurse.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training included immediate life support for all registered nurses and doctors, and basic life support for all other staff. Other modules included infection control, cyber security, data protection, moving and handling, and safeguarding. Mandatory training for managers included leading health and safety. Managers monitored compliance via an electronic system that alerted them when refresher training was due. Staff could also access the online system and they received protected time to complete mandatory training. The system was interactive and staff could monitor their own training and ensure they kept up to date.

Most staff had received and were up to date with appropriate mandatory training:

- Arkwright - 93%
- Elmhurst - 97%
- Kenton - 99%
- Wainwright - 100%

All mandatory training modules had a compliance rate of 95% or above. The site learning administrator provided regular updates and reminders to line managers, and reported to the hospital governance group if specific modules started to fall, or did fall below the compliance target of 90%.

There were options for learning, such as classroom sessions interactive e-learning followed by an e-assessment to ensure competence. There was also an audit process that randomly checked staffs' knowledge.

Assessing and managing risk to patients and staff

The low secure service provided low secure forensic care, including one ward for patients aged over 50, with a focus on maximising patients' opportunities for recovery.

We reviewed 15 care records.

Staff took a proactive approach to anticipating and managing risks to patients. All staff recognised their responsibility in this. Records we reviewed showed that staff were able to discuss risk effectively with patients. For example, there was discussion about substance misuse, self neglect, sexual vulnerability, possible public protection issues and reasons for enhanced observation. The multi-disciplinary team completed a pre-admission assessment and on admission all patients had an initial care plan that included identified risks.

Staff used recognised risk assessment tools, such as the historical clinical risk management tool (HCR-20), which assesses the patient's risk of violence in the present and future, and the short-termassessmentof risk and treatability, an assessmentof short-term risk for violence, to inform over-arching risk management plans.

Staff completed and updated risk assessments for each patient and used them to understand and manage risks individually. Risk management plans addressed all identified risks. Patients were involved in identifying their own risks.

Staff assessed, monitored and managed risk to patients on a day-to-day basis. They were aware of and dealt with specific risk issues, such as substance misuse, potentially risky behaviours or physical health issues. They identified and responded to changing risks to, or posed by, patients. Risk assessments and management plans were

person-centred, proportionate and reviewed regularly at least every four weeks or when there was clinical need. Patients and those close to them were actively involved in managing their own risks.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.

Where environmental risks had been identified, there were measures to manage them. For example, following the engagement and observation policy, ensuring robust risk management plans for all patients, and management of the environment.

Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Any staff shortages were addressed quickly and adequately.

Each ward had a designated security nurse on each shift who was responsible for access, security and safety.

Staff recognised and responded appropriately to changes in the risks to patients. There were effective handovers and shift changes to ensure that staff understood and could manage risks to patients. Staff understood the significance of developing trust, setting and maintaining boundaries and understanding the patient group dynamic. They understood how to keep patients safe from avoidable harm and provide high quality care.

Staff were trained in prevention and management of violence and aggression, including de-escalation techniques. The service did not use prone restraint techniques.

Staff also used 'reinforce appropriate, implode disruptive' (RAID) techniques. RAID uses positive behaviour reinforcement to reduce potentially violent situations. All staff including housekeepers and other ancillary staff were involved in using the technique. RAID training is provided by the Association for Psychological Therapies.

From January to December 2018, there had only been two serious incidents recorded that involved violence.

The wards participated in the provider's restrictive practice programme. There was a reducing restrictive practice steering group, membership of which included clinicians and staff who delivered prevention and management of violence and aggression training. There was a reducing restrictive practice strategy. The provider had participated in the NHS England Commissioning for Quality and Innovation framework for the last three years and met all of the indicators in each quarter. The 'safe wards' initiative had been introduced into prevention and management of violence and aggression training. This was part of a project agreed with NHS England to focus on positive and proactive care. The 'safe wards' initiative focuses on soft words, de-escalation, and positive words as well as key aspects concerning positive behavioural support plans. These included behaviours rated as red, amber or green, why they might happen, what might help and how to respond. There was also a training module for clinical staff on positive behavioural support.

Staff minimised their use of restrictive interventions. They followed best practice and the Mental Health Act when restricting patients' freedoms to keep them and others safe. They applied blanket restrictions only when justified.

The low secure wards had low stimulus rooms, and we were told that using these had helped to reduce the levels of restraint and seclusion.

There was a pattern of reduction in the use of some forms of restrictive intervention. In the 12 months leading up to this inspection, compared with the previous 12 months, incidents of seclusion had reduced from 12 to ten, of long term segregation from 12 (involving eight patients) to three (involving two patients), and of restraint from 78 (with 13 in the prone position) to 69 (with none in the prone position). However the number of times that rapid tranquilisation was used had increased from six to eleven.

Following learning shared from another site, the provider had introduced monthly audits of the use of rapid tranquilisation and the service took part in this. Lessons learned were that when physical observations were omitted due to presenting risks, this should be clearly documented in the patient's care notes and staff should document their observations of the patient's colour, pallor and overall presentation, such as how alert and orientated they were.

The numbers of incidents involving restraint was a quality performance indicator, which was monitored through the clinical governance structure. Themes, trends, lessons learned and positive practice from the use of prevention and management of violence and aggression were shared across the wards. There was a feedback survey for patients

who had required the use of prevention and management of violence and aggression. Feedback was used to inform positive behaviour support plans and improve practice, and the provider had invested in specially designed bean bags that maintained the body angle at 135 degrees, which optimised chest expansion and lung function, and minimised head trauma during restraint.

The bean bags were developed for use in healthcare environments in response to changes in guidance and trying to reduce prone restraint due to risk to the patient and staff. They have been medically risk assessed and clinically approved by a member of the Royal College of Emergency Medicine and Royal College of Surgeons.

Staff were trained to use the bean bags as part of prevention and management of violence and aggression training. Trainers were trained in their use and the safety rationale, and had annual trainer refresher courses, plus access to video sessions to refresh their learning. The provider's policy on the prevention and management of disturbed and violent behaviour provided guidance for staff.

Physical interventions were no different to how the provider trained staff when sitting a patient in a seat as the same techniques applied. However, the bean bags were easy to move so staff could manoeuvre the bean bag to the patient rather than having to move the patient. This reduced the likelihood of injury to both staff and patients and reduced moving and handling issues.

Since introducing the bean bags, the use of prone restraint in this service had reduced to one incident in 2018 and there were none recorded in 2019. Patients reported better satisfaction with the introduction of the bean bags.

The provider explained how using the bean bag had been effective in the second of two incidences of seclusion that involved the same patient, reducing the time of restraint and the use of prone restraint.

In the first incident, prolonged restraint and attempts to leave the seclusion room lasted for almost two hours, with prone restraint being required along with rapid tranquilisation. In the second incident, when the bean bag was used, staff were able to exit immediately and no prone restraint or rapid tranquilisation was needed. The multi-disciplinary team seclusion review stated that the patient appeared much calmer and reported no injuries or physical distress.

Staff understood the Mental Capacity Act definition of restraint and where appropriate they worked within it.

There was a clear culture of positive risk taking and least restrictive practice. Wards had a 'least restrictive practice' champion who provided advice and support to other staff and distributed information. Many patients had ground or community leave. Devices with connectivity were the norm. Patients had access to a range of 'real work' opportunities, both on-site and in the community. Staff used technology that selected at random patients to be searched following leave.

Access to potentially risky items was continually reviewed and controlled appropriately. Access to items such as razors was individually risk assessed and monitored. The service had worked with patients to reduce the restrictive practices around technology. Based on individual risk assessments, some patients were allowed their smart phone on the wards and their own computers in their bedrooms. There was a 'devices with connectivity' policy to ensure this was managed properly. The recovery college offered training for ensuring safety online for patients.

Self-harming behaviours comprised one of the highest rates of incidents. As part of the management of self-harming behaviour, the service had implemented various levels of observations dependent on each patient's assessed risk and management plan. All patients were engaged in developing their 'keeping safe' care plan whereby taking responsibility was encouraged and facilitated.

All patients had crisis plans that set out how they preferred to be cared for in the event of a crisis, which included if an identified risk occurred.

Staff used seclusion appropriately and followed best practice when they did so. They kept appropriate records for seclusion.

The hospital only admitted patients detained under the Mental Health Act 1983; however, sometimes patients already in hospital were discharged from detention under the Act. There was a policy to guide staff in managing these patients, and an information leaflet for patients.

Safeguarding

Outstanding ☆

Forensic inpatient or secure wards

Staff knew how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Patients were at the centre of safeguarding and protection from discrimination. There were comprehensive systems to keep people safe, which reflected current best practice and addressed patients' diverse needs. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The whole team was engaged in reviewing and improving safety and safeguarding systems. Leaders encouraged innovation to achieve sustained improvements in safety and continual reductions in harm. For example, there were monthly meetings with the local safeguarding hub to review all incidents and share lessons learnt. This had enabled 95% of safeguarding concerns to be closed.

There was a safeguarding policy and procedures for staff guidance, and safeguarding information was displayed on the wards. There was a safeguarding lead on the hospital site, and social workers also provided guidance.

Staff had received up-to-date training in all safety systems, processes and practices. Training included 'bite size' refreshers on various topics, such as self neglect, and sexual contact between patients.

Staff knew how to recognise and report abuse. They were encouraged to speak up and took a proactive approach to safeguarding, focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including patients, to agree and implement protection plans. Staff ID cards had whistle blowing information and phone numbers for concern lines on them.

There was active and appropriate engagement in local safeguarding procedures and effective partnership work with other relevant organisations, such as the local safeguarding authority. The partnership included involvement in managing concerns about people in positions of trust, whereby concerns raised about staff would be alerted to the hospital.

There were safe procedures for children visiting. Visits by children took place away from the ward.

Staff reported safeguarding events appropriately, including patient on patient and patient on staff assaults.

Staff access to essential information

Care records were stored electronically. Paper records, such as Mental Health Act documentation, were stored securely. They were also scanned onto the electronic system so that they were available to all staff when needed. Access was protected to ensure the records remained secure.

There were hard copies of records such as current observations records, which were scanned onto the electronic system once completed.

Staff maintained high quality clinical records of patients' care and treatment. They had protected time to complete documentation to ensure it was current. Records were accessible, clear and up-to-date. Each contained a one page profile of the patient so staff had quick, easy access to current, relevant information.

The systems to manage and share the information needed to deliver effective care treatment and support were co-ordinated and supported integrated care for patients. Staff could access the information they needed to assess, plan and deliver care, treatment and support to patients in a timely way.

Staff ensured that patients could transfer seamlessly between services because they shared information between teams and planned ahead. Patients understood the information being shared about them and had a copy if they wanted one. Staff involved partner agencies and carers when sharing information. They ensured that their practice supported accurate and personalised information sharing; for example, care co-ordinators could attend meetings via online conferencing facilities.

Medicines management

Staff met good practice standards described in relevant national guidance. They managed medicines consistently and safely. Medicines were stored correctly, and disposed of safely. Staff kept accurate records of medicines. Medicines reconciliation was carried out every week.

Staff regularly reviewed the effects of medications on each patient's physical health. Patients were involved in their medicines reviews.

We visited the clinic rooms where medicines were stored and looked at medicine records for 10 patients.

When required, prescribing complied with the requirements of the Mental Health Act. Prescriptions were clinically checked by the pharmacist contracted by the hospital. The governance arrangements for controlled drugs were appropriate.

Staff followed best practice when storing, administering and recording medicines. Compliance with medicines policy and procedure was monitored routinely and action plans implemented promptly. Ward managers and the pharmacist audited the use of medicines on a regular basis to identify any concerns and ensure medicines use was safe and responsive.

We found no evidence that any medicines were being used excessively or inappropriately to control behaviour.

Staff regularly reviewed the effects of medicines prescribed for mental health needs on patients' physical health. The use of medicines to treat violent or aggressive behaviour was audited to check that physical observations necessary to ensure the patient's safety were carried out.

In addition to the established audits, the provider was in the process of completing a high dose anti-psychotic drug audit, using the Maudsley national monitoring guidance.

Mental Health Act compliance and administration errors were highlighted through audit. To reduce errors, a staff education leaflet had been produced, the weekly clinic audit document altered and Mental Health Act documents reviewed in each ward round to improve Mental Health Act compliance.

Staff education also included attendance at relevant medication management training, completion of a medication management workbook, and having opportunity to reflect on and develop skills in medication management.

Track record on safety

The service had a sustained track record of safety supported by accurate performance information. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety. There was ongoing, consistent progress towards safety goals.

From January 2018 to December 2018, there had been 14 recorded serious incidents in the low secure service:

- Wainwright - 8
- Arkwright - 3
- Elmhurst - 2
- Kenton - 1

These comprised:

- Self-harm - 5
- Absent without leave - 2
- Assault on patient - 1
- Assault on staff - 1
- Medication error - 1
- Abuse by staff against patient - 1
- Patient left unattended while on escorted leave - 1
- Expected death - 1
- Unexpected death - 1

Two of the 14 incidents had occurred in the six months before we inspected. All the incidents had been investigated.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff at all levels were open and transparent. They recognised incidents and reported them appropriately. They understood their responsibilities to raise concerns and report incidents and near misses and were fully supported to do so.

It was recognised that incidents were distressing for patients, staff and professionals involved and the importance of how discussing incidents promptly and compassionately helped reduce the potential impact. Following serious incidents, staff and patients received de-briefing that incorporated support and reflective discussion and input from a psychologist. Incidents were also discussed in clinical supervision, team incident reviews and staff meetings. Staff also discussed any incidents with patients, their families (with their consent), carers and other professionals involved in their care.

There was a genuinely open culture in which safety concerns raised by staff and patients were considered fundamental to learning and improvement. All incidents fed into daily managers' meetings and were discussed at handover and in reflective practice meetings. Where necessary, incidents were escalated for further

investigation. The monthly clinical governance committee meetings had oversight. Where action points and recommendations were made these were followed up in weekly senior management team operational meetings. Staff also had discussions with patients about their management preferences.

Learning was based on analysis and investigation of things that went wrong, that involved all relevant staff, partner organisations and patients. Lessons learned were communicated widely to support improvement in other areas as well as services directly affected. All staff were encouraged to participate in learning to improve safety as much as possible, including working with others in the system.

Immediate lessons learnt were shared via the site co-ordinator across all the wards and departments. Incidents data was collated monthly for themes and shared via publications, briefings, incident review reports and ward planning and development meetings. Learning was also accessed via the service intranet.

The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality. Staff understood the duty of candour. When things went wrong, they apologised and gave patients honest information and suitable support.

We saw evidence of learning and improvements to safety being made following incidents; for example, engaging patients to be fully involved in their care planning processes, addressing the 'keeping safe' component where responsibility is encouraged and facilitated, the introduction of specially designed bean bags for use in restraint, and facilitating dialectical behaviour therapy skills training for ward teams.

The service monitored changes made through looking at trends, quality walk rounds, supervision and audit.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Outstanding ☆

Assessment of needs and planning of care

We reviewed 15 care records.

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.

There was a holistic approach to assessing, planning and delivering care and treatment, supported by evidence based practice. Leaders actively encouraged the safe use of innovative approaches to care and how it was delivered, such as implementing new assessment tools and outcomes measures, and utilising research findings to make improvements.

Patients all had comprehensive assessments of their needs, which included consideration of their clinical needs including pain relief, mental health, physical health and wellbeing, and nutrition and hydration needs. Assessments focused on patients' strengths, self-awareness and support systems.

Care plans were holistic, personalised and recovery-oriented, and demonstrated staff's understanding of current, evidence-based practice. They focused on recovery in terms of relapse prevention, early warning signs, reducing self-harm, and developing individual support systems. Care plans identified outcomes for each identified need and the pharmacological, psychological and therapeutic interventions needed to achieve the outcomes.

Patients and staff identified expected outcomes together, and they regularly reviewed and updated care plans together. There were clear care pathways and appropriate referrals to make sure that needs were addressed. Staff recorded and monitored information about patients' care and treatment and outcomes.

Patients and staff had regular sessions to review their care needs, and they attended review meetings with the multi-disciplinary team. Families and carers were encouraged to be involved. Care co-ordinators were invited and could attend via online conferencing facilities.

Best practice in treatment and care

Staff planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice, legislation and technologies. They implemented

evidence-based guidance in their clinical practice; for example, relating to risk management, aggression and violence, and schizophrenia, and when making prescribing decisions. Care plans also referenced national guidance.

Staff monitored their practice to ensure consistency. The supervision records we reviewed confirmed that staff were using national guidelines, for example, in relation to risk management.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). Interventions included medication, psychological therapies and activities, and training and work opportunities intended to help patients acquire living skills. Invasive interventions such as restraint and rapid tranquilisation followed best practice. There was a policy to provide guidance for staff and clear documentation in care records to explained why these interventions were necessary.

The provider monitored the NICE website for relevant new or updated guidelines and quality standards. When new guidelines were published, a summary of the main points and requirements, together with a link to the relevant pages of the NICE website and the full guidelines was disseminated throughout the wider hospital team.

A spreadsheet of current NICE guidelines and quality standards was accessible to all staff via the intranet. The spreadsheet provided a summary and a link to the full guidelines.

There was a clinical network structure that met every quarter to discuss, share and monitor best practice, including reviewing and implementing NICE and national guidelines as appropriate. For example, the NICE guidelines for suicide and learning disability had been reviewed, and a full action plan undertaken to ensure compliance.

A team of psychologists delivered a comprehensive programme of therapeutic interventions. Sessions took place in groups and one-to-one personalised programmes. Patients could refer themselves for therapies or the multi-disciplinary team could make a referral.

Interventions were evidence-based and recovery focused. They included motivational cognitive behaviour therapy techniques, group work skills, a 'life minus violence' enhanced programme, sexual behaviour management, mastering a 'skill of the week', a responsible living group, emotional regulation, mindfulness, substance misuse awareness, dialectical behaviour therapy and cognitive behavioural therapyapproaches that emphasised consequential thinking. Patients were involved in developing their own treatment programmes.

The dialectical behaviour therapy team had won the Association for Psychological Therapies (APT) award for excellence, judged against criteria of excellence and likelihood to inspire others. This was the fourth APT award that the team had won in the last three years.

The provider also offered 'recovery college' courses to improve patients' health and wellbeing and provide education and skills development opportunities. This was in partnership with local colleges. A 'recovery college' is a course of workshops designed to increase awareness and understanding of recovery and what it means to each individual. Patients were involved in producing and facilitating courses.

The occupational therapy team had a specific focus on developing functional skills. These included promoting independence in personal care tasks, developing optimum skills in more complex tasks, such as managing a budget and engaging in work type occupations, and providing access to a range of community-based voluntary experiences, supported work and recreational activities.

The hospital site included a horticultural area, a woodland walk, a fitness suite and sports hall, including a badminton court, music facilities, an education suite, workshops for art and woodwork, a library, therapy rooms and social areas.

Staff also implemented 'reinforce appropriate, implode disruptive' (RAID) techniques across all therapies and activities. RAID uses positive behaviour reinforcement to deal with potentially violent situations. It is a recognised industry standard method of working with patients to help them manage their own behaviour. Since our last inspection, Kemple View had developed RAID across the site, and had maintained its accreditation as a RAID Centre of Excellence. Being recognised as a RAID Centre of Excellence means that that the organisation is implementing RAID principles outstandingly well, using a positive approach to interventions. The centre of excellence status is re-appraised at least every two years to ensure its current validity.

Forensic inpatient or secure wards

Wherever possible, information about patients' physical health was obtained before admission. On admission, patients were examined immediately or as soon as practically possible by the practice nurse or a doctor. A full assessment of their physical health needs was completed, which formed part of their mandatory 'keeping healthy' care plan, and repeated every quarter. Staff used the Lester tool to assess patients' physical health. Monitoring included blood tests, electrocardiograms and monitoring the side effects of medication.

Staff ensured a comprehensive 'keeping healthy' care plan was developed based on the patient's identified physical health needs, including sexual health, smoking, alcohol misuse, illicit substance misuse, weight, exercise and diet. This was completed as soon as possible by requesting any background and necessary information from the patient's GP and other relevant sources. Staff monitored and maintained patients' 'keeping healthy' care plans.

Staff monitored patients' ongoing physical health needs and all issues were discussed at ward reviews. All identified needs were comprehensively documented in the patient's physical health care plan, 'keeping healthy'. All care plans were reviewed monthly or following any clinical change to ensure each patient's physical health needs were met appropriately based on the evidence of relevant national guidelines.

There was an audit process to monitor patients' physical health assessments.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. A full-time practice nurse and a physical healthcare assistant were responsible for physical healthcare across the site. All patients had access to an on call doctor and weekly access to the visiting GP to ensure their physical health needs were met appropriately. There was also a monthly chronic illness management clinic held on site. This was part of the service level agreement with the local GP practice.

The practice nurse carried out therapeutic drug monitoring for patients prescribed medicines such as clozapine, to ensure their physical wellbeing. They also ensured patients had full written information before commencing the medication. Physical health monitoring following rapid tranquilisation was carried out routinely.

Staff were consistent in supporting people to live healthier lives, including identifying those who needed extra support, through a targeted and proactive approach to health promotion and prevention of ill-health, and they used every contact with patients to do so.

There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing. Patients had produced leaflets about the physical health strategy.

Staff offered health promotion activities to patients, such as walking groups, cycling, healthy eating, including 'fake away' nights where patients cooked a healthy meal together, access to the gym and men's health initiatives. Smoking and vaping was banned on site. Smoking cessation information was prominent on the wards. Nicotine replacement therapy was available and promoted. Staff educated patients about the effects of smoking on medication. Drinks and snacks in the café and shop on-site were sugar free and low fat wherever possible.

There was a weight management initiative called 'mission fit', facilitated by a fitness instructor who conducted an educational programme about healthy living and encouraged participation in exercise sessions. The programme targeted and catered for service users in a mental health care environment. Patients were challenged to lose 5% of their starting body weight over 12 weeks. The programme incorporated education about healthy living as well as taking part in exercise sessions. Since our last inspection, 'mission fit' had been developed so that after the first 12 weeks, patients were offered continued involvement to maintain their weight loss and to encourage healthy lifestyles.

This included group and individual sessions, healthy lifestyle advice, practical physical activity, advice on healthy eating, tackling motivation and identifying ways to get more active. This was supported with activity such as football, circuits, volleyball, hockey, badminton, gym and tennis. Staff and patients had completed the 'couch to 5k' initiative, a running plan for beginners. Mission fit also offered nutritional advice, ward based sessions, walking groups, boxercise, exercise challenges and twice weekly sessions for staff. 'Mission fit' also offered a service user a real work role and had trained them to plan, prepare and facilitate 'mission fit' sessions.

'Mission fit' also had links with the local community. Following sessions on site patients were offered community gym sessions and community boxing sessions. There were partnerships with two local gyms that patients could access. This created a pathway for establishing physical activity as a part of their recovery back into the community.

With the agreement of the multi-disciplinary team, patients could also take part in boxercise sessions, first on site and then in the community at a local gym. Patients were reminded about their behaviours while using the boxing equipment, that having the gloves was a privilege and that nothing learnt in sessions should be taken back to the wards.

Staff were actively engaged in activities to monitor and improve quality and outcomes. They routinely collected and monitored information about patients' care and treatment and their outcomes. They used nationally recognised assessment tools, such as the historical clinical risk management-20, the short-term assessment of risk and treatability and the health of the nation outcome scales.

The low secure service had recently undertaken two research initiatives. They used the findings to improve care. The research comprised:

1. an evaluation of the psychosis care pathway for patients detained in a secure setting.

Recommendations included:

- training and development
- changes to care plans
- reviewing how staff helped patients to communicate
- ensuring staff felt fully supported in their roles
- motivating patients to change
- considering adaptations to the ward environment to help patients' mobility.

Changes were made within the mental health awareness group as a result of the findings of this study, which included:

- a measure of readiness to change and a knowledge based questionnaire was added to the assessment battery, enabling the treatment team to look at knowledge gains made by participants, in addition to the attitudinal information captured by other measures
- changes made to sessions, specifically in relation to how assertiveness skills were introduced and discussed
- opportunities for practice and development of the skills
- adaptations within sessions to meet the responsivity needs of group members.

2. exploring quality of life related factors in the care of older adult mentally disordered offenders in a low secure forensic psychiatric hospital. Members of the psychology department developed a series of workbooks and a mental health awareness programme based upon what was known to work well in the psychological treatment of psychosis.

The findings were that:

- patients knew more about mental illness than they did before completing the workbooks
- specifically, they knew more about what could improve mental health and what could make it worse.

Changes were made as a result of the findings of this study, which included:

- increase in staff trained to assess for equipment (occupational therapy)
- review of hospital transportleading to increased provision for wheelchair accessible vehicles
- introduction of a local shuttle bus from the site to local towns, which made provision for larger groups and freed up vehicles for wards to access
- staffing reviewed daily, and recruitment lessened the need for bank staff to be utilised
- all patients had a communication plan.

Some patients were using the health of the nation outcome scales to measure their own progress.

Outcomes for patients were positive, consistent and met expectations. Staff shared information about effectiveness in multi-disciplinary team meetings and clinical governance meetings. The provider published reports internally and externally, and the service used the information to improve care and treatment and patients' outcomes.

Staff used technology to support patients effectively. They used electronic dashboards to monitor patients' health scores, in accordance with the provider's physical health strategy. Care records included full physical health care checks, including a routine annual electrocardiogram and blood tests. They used the Liverpool University neuroleptic side effect rating scale to monitor the side effects of medication.

Forensic inpatient or secure wards

Staff participated in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review. Accurate and up-to-date information about effectiveness was shared internally and externally and understood by staff. It was used to improve care and treatment and people's outcomes and this improvement was checked and monitored.

High performance was recognised by credible external bodies, such as the Royal College of Psychiatrists. The low secure service was an established member of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services. The service had been peer reviewed in April 2019 to assess progress against recommendations at the 2018 review, when they successfully met 90% of the quality standards.

The provider had completed an audit of the collaborative physical health assessments (Lester tool) in May 2018. This was repeated in January 2019 and the data undergoing analysis.

There were weekly reports on care plan compliance. Any areas of concern were monitored and addressed. Completion of physical health assessments was one of the quality performance indicators. In addition, 'documentation' quality walk rounds monitored patients' physical health needs and ensured key information was up-to-date and relevant.

The provider had completed a Mental Health Act audit for each patient. The audit tool covered basic patient data, care planning and assessments, section 17 leave documentation, treatment under section 58 and information to patients under section 130d and 132.

A spreadsheet was maintained for all detained patients with reference to section renewals, mental health tribunals and consent to treatment status. There was an admissions checklist completed for all patients. A 'documentation' quality walk round also monitored whether patients' capacity to consent to treatment had been assessed in a timely way with the correct documentation in place. Any issues arising from these audits were scrutinised and responded to appropriately through the service's clinical governance meetings.

The service had participated in the national audit of schizophrenia in September 2018, auditing prescribing practice, physical health monitoring and activity within psychological therapies.

There had also been an audit to establish the extent of high dose and combination antipsychotic prescribing. The reason for the audit was that high dose and combination antipsychotic treatment is associated with a higher risk of physical health problems. The audit therefore included consideration of the necessary physical health monitoring of patients on high dose antipsychotic therapy. In view of the limited evidence of benefit from using high dose or combined antipsychotics, the audit checked that effectiveness was monitored.

The provider had audited the service against the national guidelines for mental health services for patients with a learning disability and subsequently developed practice in this area of care. Some patients also had care and treatmentreviews alongside the care programme approach; thus, there was a clear link with learning disability and autism specialist services.

As part of their annual internal auditing mechanisms, the service were in the process of auditing observation and engagement practices and evaluating risk assessments on the electronic system.

The service had reviewed the risk assessment audit, and found issues relating to patients' privacy and dignity. There was an action plan to produce specific care plans addressing this.

Seclusion audits were carried out each time a patient came out of seclusion. The audits were reviewed and the findings fed back to the ward staff.

A meaningful week audit was completed every week ensure that each patient had a minimum of 25 hours of activities planned for the coming week. If there were any patients that did not have activities planned or fell below the 25 hour minimum expectation the ward managers were notified. There was a recovery worker for every ward, who were not included in the 'safe staff' numbers. This meant there were always staff available to facilitate activities and escorted leave.

Each week, managers checked that clinical notes had been signed by practitioners and a report sent to department heads, who then ensured that any unconfirmed notes were signed, assuring good general data protection regulation practice.

There was an infection control audit in June 2018. This covered cleanliness, catering and a clinical perspective, involving the whole team. Current progress indicated green overall with a small number of amber actions relating to maintenance issues, which were in progress.

A ligature audit was completed in January 2019. The risk register was updated to reflect findings regarding wardrobe doors. Actions had been taken to mitigate the identified risk.

The provider participated in an annual safeguarding audit as a quality performance indicator. The audit related to performance in documentation, training and governance. All safeguarding concerns and CQC notifications completed were reviewed. They met monthly with the local safeguarding authority to review all safeguarding referrals (including those that did not meet the local authority threshold) to ensure any learning was shared.

The patient reported experience and outcome measures NHS England audit was completed in November 2018.

The provider had participated in a limited audit of reducing restrictive practice. This triggered an internal benchmarking exercise against national restraint reduction network standards. There were established themes and work streams and a project steering group to take forward the actions from this exercise. These were to eliminate prone restraint and to carry out a review of reducing restrictive practice.

The provider commissioned ex-patients to peer review patient and staff views of reducing restrictive practice projects and their effectiveness. The review was undertaken by facilitating on-site discussion forums, individual meetings and review of all reducing restrictive practice documentation and processes.

A book was provided on each ward for all patients and staff to document a suggestion or query regarding any restrictive practice. These were reviewed at weekly community meetings and monthly ward planning and development meetings, and escalated to service user council and hospital governance meetings.

Skilled staff to deliver care

Patients had access to the full range of specialists required to meet their needs. This included occupational therapists, clinical psychologists, social workers, pharmacists, speech and language therapists, a GP, podiatrists, physiotherapists, dentists and dieticians as well as medical and nursing staff.

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care and managers made sure that staff had the opportunity to develop the skills they needed. Managers proactively supported and encouraged staff to acquire new skills, use their transferable skills, and share best practice.

We reviewed six staff records. Staff were experienced and qualified. They had the right skills and knowledge to carry out their roles effectively and in line with best practice, to meet patients' needs. They had accessed a range of training. Managers supported staff through appraisals, supervision and opportunities to update and further develop their skills.

New staff had a comprehensive induction that incorporated the care certificate for non-registered clinical staff. The care certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It sets out national standards that underpin the required skills, knowledge and behaviours to ensure staff provide compassionate and high quality care and support.

Induction included the ethos of person centred care, values-based approaches, collaborative risk assessments and a conflict management course that included primary, secondary and tertiary preventative strategies.

The provider's values were linked to supervision and appraisal. Managers supported staff to deliver effective care and treatment through annual appraisal and regular supervision meetings, to discuss case management, to reflect on and learn from practice, for personal support and professional development, and appraisal of their work performance. They ensured that staff had access to regular team meetings.

All staff had had an appraisal in the 12 months before this inspection. Appraisal included setting objectives for personal development.

Staff received monthly supervision. There was a policy that provided guidance for staff. Supervision was established in the service culture. As well as formal records of supervision meetings, staff also kept an individual supervision 'passport' where they recorded all types of supervision. This included group supervision, reflective learning and informal discussions as well as regular meetings with their supervisor.

Management supervision included key performance indicators for staff, such as all assessments and care plans having been completed in a timely manner and one-to-one sessions with patients taking place. Records included discussion of appraisal objectives, national guidance, training needs and training undertaken, and patient engagement.

Staff also received monthly clinical supervision. This could be through individual or group supervision, or specialist peer supervision if that was appropriate. Staff were able to choose their supervisor. Clinical supervision ensured staff could develop the skills needed to ensure patients received high quality care, treatment and support. It provided guidance for individual development and an opportunity for staff to feel supported, motivated and confident.

Individual staff had a supervision contract with their supervisor that included agreed ground rules, and they kept their own confidential notes.

Most staff had received and were up to date with both clinical and management supervision:

Arkwright - 80%

Elmhurst - 89%

Kenton - 100%

Wainwright - 100%

There was a strong focus on improvement and many opportunities for learning and sharing across the service. Staff were encouraged to take time out to consider their practice and make improvements; for example, monthly reflective practice meetings were available for all staff. They said the opportunity to discuss challenges they encountered in their practice was invaluable in considering how care and treatment could be improved. These meetings enabled staff to explore the dynamics of the ward, or focus on the care and treatment of one particular patient and discuss strategies and approaches for dealing with this as a team. Themes of discussions in reflective practice meetings also included changes to therapeutic treatments in line with the changing patient population.

Medical staff were supported through the process of revalidation. One doctor required and had been revalidated in the 12 months prior to this inspection.

Staff and managers identified learning needs as part of the supervision and appraisal process. Managers ensured that staff received the necessary specialist training for their roles. They provided staff with opportunities to build on their skills and supported them to develop their knowledge and experience.

Managers encouraged staff to develop skills in specialist areas; for example, one nurse was being supported to become a practice nurse. Staff from other disciplines told us that they had been supported to gain further experience and qualifications, so that patient care was improved.

Some nurses had previously been health care support staff. The provider supported them through training to become registered nurses.

In 2018, the provider had launched a career pathways project and all staff were enrolled onto a pathway that set out their potential career progression.

Managers dealt with poor staff performance promptly and effectively. There was a clear and appropriate approach to supporting and managing staff when their performance was poor or variable. Staff and managers discussed performance in supervision. Staff were encouraged to reflect on their practice and performance. This was evident in the records we reviewed. Managers explained the process they followed and told us they were very well supported in addressing poor performance.

Multi-disciplinary and inter-agency team work

Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services.

When patients received care from a range of different staff, teams or services, it was co-ordinated. All relevant staff, teams and services were involved in assessing, planning and delivering patients' care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patient's needs. The multi-disciplinary team

(MDT) worked effectively to co-ordinate person-centred patient care and support patients' recovery in line with best practice guidance. The MDT held weekly meetings, with each patient's involvement. They planned care and treatment in a holistic, patient-focused way and established the patient's views to ensure they were involved in developing their care plan. Open invitations were offered to care co-ordinators and carers, and there were good relationships with community teams.

There were handover meetings at the change of every shift. Staff discussed issues relating to patient safety, risks and observation levels.

Every morning, senior managers and all ward managers met to review issues such as referrals, admissions, discharges and transfers, reported incidents, observation levels, risks, safeguarding and complaints. We attended one of these meetings and found it to be well structured, informative and productive.

Staff held regular and effective multi-disciplinary team meetings, where they shared information about patients. Care co-ordinators were invited to the meetings and could attend via online conferencing facilities.

There were established, positive working relationships with referring clinical teams and care co-ordinators, and other service providers such as local authority social services, GPs, chiropody, opticians, podiatry and physiotherapy, and with a range of community groups where patients could undertake voluntary and vocational work placements. Some patients were involved in charity work such as supporting veterans in the community and conservation work.

Patients' discharge, transition and referral plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes.

Staff took a holistic approach, which began at the earliest possible stage. Staff from different disciplines, teams and services worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. Patients were discharged at an appropriate time and when all necessary care arrangements were in place.

Where discharges, transfers and transitions occurred unexpectedly, there were processes that ensured patients were not left at risk, including communicating their specific, individual needs.

Adherence to the MHA and the MHA Code of Practice

Training in the Mental Health Act (MHA) was mandatory, and 88% of staff had had training.

Managers supported staff to understand and meet the standards in the Mental Health Act Code of Practice. They understood their roles and responsibilities, and managers made sure that staff could explain patients' rights to them. They did this every month. They explained in ways that patients could understand and recorded that they had done it. They repeated the information when necessary. Patients understood their rights under the Act and they were empowered to exercise them. Some patients had exercised their right to appeal to the mental health tribunal (MHT) and/or the hospital managers. When necessary, the service had made referrals to the MHT. Decisions were recorded and patients were informed about decisions.

Staff worked effectively with others to promote the best outcomes for people subject to the MHA, with a focus on recovery.

Where patients were subject to the Mental Health Act, their rights were protected and staff complied with the associated Code of Practice. Adherence to the MHA and Code of Practice was good.

All treatment was given under appropriate legal authority and the relevant certificates were in place, along with review of treatment documentation for patients assessed as not being capable of understanding the nature, purpose and likely effects of the treatment. The responsible clinician had noted the patients' capacity to consent to treatment at the most recent authorisation. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff had good access to administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff knew who the Mental Health Act administrators were.

There were relevant policies and procedures that reflected the most recent guidance. Staff had easy access to the policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. There was an independent mental health advocate who provided support to patients on request.

Outstanding ☆

Forensic inpatient or secure wards

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted. All patients had section 17 leave, either in groups or individual.

Staff stored copies of patients' detention papers and associated records, such as section 17 leave forms, correctly. Staff had followed the procedures for renewing detention and the criteria for renewal had been met. The records were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely.

Care plans referred to identified section 117 aftercare services for patients who had been subject to section 3 or part 3 powers authorising admission to hospital.

Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly, and there was evidence of learning from those audits. An audit had been completed for each patient in September 2018.

Good practice in applying the MCA

Training in the Mental Capacity Act (MCA) was mandatory, and 95% of staff had had training.

Staff understood and complied with the requirements of the MCA and the five statutory principles.

There was a policy on the Mental Capacity Act, including the Deprivation of Liberty Safeguards. Staff had easy access to the policy and they understood it. They knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards. The social work team provided guidance.

Consent to care and treatment was obtained in line with legislation and guidance. Staff assumed that patients had capacity and they supported patients to make decisions about their care for themselves. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

Staff understood that capacity fluctuated and that patients may have capacity to consent to some things but not others. They gave patients every possible assistance to make a specific decision for themselves before they considered that the patient might lack the mental capacity to make it.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Practices around consent and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.

Use of restraint was understood and monitored. Less restrictive options were used wherever possible.

Deprivation of liberty was recognised and only occurred when it was in a patient's best interests, was a proportionate response to the risk and seriousness of harm to the patient, and there was no less restrictive option to ensure the patient received the necessary care and treatment.

There were no patients subject to the Deprivation of Liberty Safeguards and there were no pending applications.

The service monitored adherence to the Mental Capacity Act. They audited the application of the Act and took action on any learning that resulted from it.

Are forensic inpatient or secure wards caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. They treated patients with compassion and respect. They respected patients' privacy and dignity, and supported their individual needs. Relationships between patients, those close to them and staff were caring, respectful and supportive. These relationships were valued by staff and promoted by leaders.

Care plans were holistic, personalised and recovery-oriented and patients' involvement was clear. Their specific preferences and needs, including their emotional and social needs, were reflected in how staff delivered care.

Patients were treated with dignity by everyone involved in their care, treatment and support. Consideration of patients' privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated. Patients' emotional, social and physical needs were considered equally. Staff responded compassionately when patients needed help. They anticipated patients' needs and supported them to meet their basic personal needs. They supported patients and those close to them to manage their emotional responses to their care and treatment.

Staff supported and enabled patients to manage their own health and care when they could and to maintain their independence as much as possible. They directed patients to other services when appropriate and supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them. Feedback from patients, those close to them and stakeholders was positive about the way staff treated patients. Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Patients felt supported and said staff cared about them.

They valued their relationships with the staff team. Staff understood patients' individual needs, including their personal, cultural, social and religious needs and took them into account. They recognised and respected the totality of patients' needs and ensured they could meet them. They supported patients to maintain and develop their relationships with those close to them, their social networks and the community.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Patients, those close to them and staff all understood the expectations of the service around privacy and dignity. Staff developed trusting relationships with patients. They recognised the importance of patients' privacy and dignity, and they always respected it. They challenged behaviour and practices that did not meet expectations.

Staff always respected patients' confidentiality. They met legal requirements about data protection. When patients' care and support was provided by a mix of different providers, the service minimised risks to privacy and confidentiality.

Involvement in care

There was genuine commitment to patient involvement. At the beginning of the inspection, patients, staff and the hospital director gave a presentation of their achievements and plans. Empowering and involving patients was clearly embedded in the hospital culture.

Staff supported patients to have a voice and to realise their potential. They communicated with patients and provided information in a way that they could understand. Patients understood their condition and their care, treatment and advice. Patients and staff worked together to plan care and there was shared decision-making about care and treatment. Patients' individual preferences and needs were always reflected in how care was delivered.

Patients and those close to them were active partners in their care. Patients, carers and family members were involved and encouraged to be partners in making decisions about care, and receive any support they needed. Staff spent time talking to patients and those close to them. Staff were fully committed to working in partnership with patients and making this a reality for each patient. Patients told us they understood their care and treatment. Staff supported patients to take as much responsibility for developing their care plans as they could. They were involved in planning and making decisions, including about discharge and about how they wished to be treated if a crisis occurred. Care plans were written from the patient's viewpoint. Their involvement in developing their own care plans was documented. They added their own notes to their care records. Patients were all offered a copy of their own care plan. With the patient's agreement, their family, friends and advocates were also involved. Staff facilitated carers' involvement.

Patients had been involved in the recruitment and interview process for all staff. They were also involved in the induction process and provided an overview to new staff.

Outstanding ☆

Forensic inpatient or secure wards

Staff valued feedback as an essential mechanism to ensure they understood patients' expectations, experiences and needs, and could learn and implement any changes from their feedback. There were systems to ensure patients could give feedback and their views were considered.

Patients' experiences were captured via various mechanisms including patient satisfaction surveys, using online and hard copies, and compliments books. Some ex-patients visited to talk to current patients about the treatment programme.

Patients were represented on several groups, such as the physical health group, recovery college group and ward planning and development teams.

The documentation and service user quality walk rounds monitored patient and carer involvement in the development of care planning. The results were used to improve on quality and standards.

There were weekly community meetings on the wards, chaired by nominated patients. Patients had opportunity to discuss wider hospital issues and contribute to the day-to-day running of the ward. Staff actively encouraged them to take part in community meetings. Minutes and actions from the meetings were displayed on the wards. The minutes documented discussion about issues patients raised and there were action plans to address them.

There was a monthly service user council meeting that discussed matters raised by patients. All wards had patient representatives on the service user council. All patient representatives were encouraged to attend the meetings. The hospital director chaired the service user council meetings and all heads of departments attended.

A representative of the service user council also attended the clinical governance meetings. They raised additional issues as needed, and provided updates on issues that required attention from the wards. We saw meeting minutes that confirmed the respect given to patients' views and opinions.

A service user experience of care survey was carried out in 2018. The data collected across both wards was mostly positive, with some very positive comments from service users. All service users who completed the survey agreed they felt safe on the wards and that staff were supportive and treated them with respect. Comments included, 'staff are the best' and 'staff are very helpful and supportive'.

Patient reported experience and outcome measures NHS England audit surveys were carried out every quarter. The results were discussed at clinical governance meetings and associated actions from the reports allocated to the appropriate heads of departments.

Recent local survey comments had reflected a need to review menus and food provision. To address this, the head chef established focus groups to take feedback and incorporate comments into menu planning.

Direct feedback from patients had suggested that activities were inconsistent in their delivery and that in some instances, where there were vacancies in the occupational therapy team, activities were largely self-led. As a direct result of these comments, agency occupational therapy staff were engaged.

There was a survey of a small sample of three out of seven patients discharged between October and December 2018. The results were mainly positive. An action plan was drawn up and completed to ensure an increased response rate going forward, so that more meaningful data could be gathered.

There was an annual family and friends survey. In 2018, the results were mainly positive, with carers feeling respected, understood and communicated with. The results were analysed and an action plan produced to improve practice. The action plan was further developed in a family and friends event held in March 2019.

There were quarterly carers' meetings, which had a high attendance rate. There were incentives for carers to attend the group, such as being able to have lunch with their loved one, or scheduling a visit either before or after the meeting. Carers were involved with a range of issues, including training. This supported carers and patients to form wide support networks.

Staff ensured that patients could access advocacy. They recognised that patients needed to have access to, and links with, their advocacy and support networks in the community and they supported patients with this. Staff ensured that patients' communication needs were understood, followed best practice and learned from it. Patients had direct access to advocacy services and there was information displayed on the wards.

Outstanding ☆

Forensic inpatient or secure wards

Staff gave families and carers appropriate information, and provided them with support when needed. They gave carers advice on how to access a statutory carers' assessment, provided by an appropriate agency. They provided each carer with a carers' information pack.

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

Access and discharge

The service specialised in long term, complex patients, some of whom had specific risk histories or life limiting illnesses. Access to care was managed to take account of patients' needs. Waiting times from referral to treatment, and arrangements to admit, treat and discharge patients were in line with good practice.

Staff used the care programme approach as a framework and timeline for planning and co-ordinating support and treatment.

Patients were admitted from a range of different settings including secure units, prisons and other inpatient units. All admissions were planned.

There were clear care pathways. Patients were assessed before they were admitted so that they received the most appropriate care and treatment.

Between 1 July and 31 December 2018, average bed occupancy was:

- Arkwright - 89%
- Elmhurst - 99%
- Kenton - 93%
- Wainwright - 100%

For current patients, at 31 December 2018, average length of stay in days was:

- Arkwright - 1329
- Elmhurst - 99
- Kenton - 857
- Wainwright - 1221

Of patients discharged during the 12 months up to 31 December 2018, the average length of stay in days was:

- Arkwright - 1614
- Elmhurst - 734
- Kenton - 1218
- Wainwright - 1612

The length of stay in low secure units is at least 2 years, depending on the nature of the offending or challenging behaviour and psychopathology.

The average length of stay for each ward was reflective of patients' needs.

There was always a bed available when patients returned from leave.

Patients were not moved between wards unless it was justified on clinical grounds and was in their interests.

When patients were moved or discharged, this happened at an appropriate time of day. Staff supported patients during referrals and transfers between services; for example, if they required treatment in an acute hospital.

Staff took a holistic, person-centred approach to support patients in their recovery. They ensured patients did not stay in hospital longer than necessary.

Staff planned for patients' discharge, including good liaison with care co-ordinators, to ensure patients had the support they needed when they were discharged. Discharge was never delayed for other than clinical reasons.

Between 1 July and 31 December 2018 there were three delayed discharges:

- Elmhurst - 1
- Wainwright - 2

There were no readmissions within 90 days.

Staff considered discharge arrangements from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. Care records contained plans for discharge, transfer or transition to other services, including potential future placements. Discharge plans were developed in care planning. Patients were engaged in community based activity as much as possible, such as education and employment opportunities, and staff supported them to develop social networks. Leave was used to monitor patients' progress towards discharge.

Discharge plans were reviewed and updated at each multi-disciplinary team meeting. Patients knew approximately when they would be discharged and where to.

Patients were admitted from various parts of the UK due to placements that would meet their needs not always being available in their home area.

Staff worked closely with care co-ordinators, commissioners and other providers to plan and facilitate discharges and ensure patients were fully supported. Discharges or transfers were discussed and planned by the multi-disciplinary team. The service followed national standards for transfer.

There was a policy for unplanned discharge, along with identified actions in the care plans.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings supported patients' treatment, privacy and dignity.

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. All bedrooms were en suite. Patients always had access to their rooms. They had personalised their bedrooms, and all had secure lockable storage for their possessions. Banned items, such as cigarettes and lighters, were kept securely by staff.

The bedrooms had vistamatic windows covered by a blind that patients could operate from inside their rooms.

Patients had access to the gardens on all wards. The gardens were secure with a high fence. There was seating and raised flower and vegetable beds that patients tended. The hospital grounds were spacious with gardens, a woodland walk and seating areas.

Staff and patients had access to a full range of rooms and equipment to support care and treatment. Each ward had a range of therapy rooms, a clinic room, a visiting room, a large lounge and two kitchens. One kitchen was for occupational therapy assessments or for patients to cook on their own. On all wards, this kitchen was kept locked.

Patients could make drinks or snacks whenever they wanted to in the main ward kitchen, which was kept open. They had individual lockers to store non-perishable food items.

Staff supported patients who were self-catering to budget, shop for and cook their own food.

There were quiet areas for privacy and where patients could be independent of staff.

There was a pay phone on each ward where patients could make a private phone call. Access to mobile phones, including smartphones, was individually risk assessed.

Patients had access to a computer and could access the internet although they had to ask staff for a password.

Most patients thought the quality of food was good. Staff sought regular feedback on the quality of food.

There was a wide range of activities available seven days a week, both on and off the wards. Each ward was trialling having a dedicated activity nurse, who was not included in the safe staffing numbers.

The activity programme provided opportunities for personal growth and development of social and inter-personal skills. Therapeutic activities included woodwork, art, music groups, swimming, cycling, walking, a gym, smoking cessation and mindfulness groups. There was also access to a horticultural area, IT suite, an education centre, therapy rooms and a sports hall.

All patients had a timetable to identify their individual activity and support needs. There was also a timetable of open groups that anyone could join in. The activities were varied and took place all through the week, including weekends. Some continued into the evening. Activities were personalised to accommodate patients' preferences, provide support and promote community and social inclusion, with the focus on recovery and safe rehabilitation into the community.

The sports hall was also used for social events such as cinema nights, and patients could access the on-site gym after 5pm as well as during the day. Activity focused on promoting recovery and developing skills to maintain independence.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

They supported patients to maintain contact with their families and carers. They facilitated visits home and with

the people close to them. Patients could use online conferencing facilities to keep in touch with the people close to them. Patients had also facilitated a family and carers' open day.

Staff encouraged patients to use community facilities wherever possible. This promoted appropriate behaviour and life in the wider community. Leave authorised under section 17 Mental Health Act 1983 was well structured, so that patients could access a range of activities.

The service had several community partners, such as local colleges for the recovery college, a local football club, sports initiatives, voluntary organisations and user forums. The service user council was represented on the committees of these groups.

There were innovative approaches to providing integrated person-centred pathways of care that involved other organisations and the local community. This was fundamental to planning and ensuring that the service met patients' needs. Staff supported patients to take part in mainstream activities and to exercise their right to be a citizen as independently as they were able to.

Patients had access to a range of 'real work' opportunities, both on-site and in the community.

There was an excellent range of joint initiatives that the service had developed with external organisations.

Patients applied and attended interviews for these opportunities and received training to support them. On-site opportunities included being involved in staff recruitment, induction and training. Other opportunities included working in the on-site café, painting and decorating, catering, horticultural work and looking after animals.

Patients also participated in community groups and activities; for example, neighbourhood groups, learning, and volunteer opportunities, such as conservation work, working at an animal sanctuary, working at a food bank and food kitchen, and supporting veterans. Patients also took part in training sessions with a local football club. One patient had gained his FA level 1 coaching badge. Another patient had presented their story to 80-90 people at a boot camp. This reinforced the focus on access to education and employment opportunities. Patients and staff viewed these opportunities as positive, recovery focused work experience.

Patients had access to recovery college courses, developed in partnership with local colleges. There was a team of tutors and education facilitators who supported patients to access a range of educational opportunities. The recovery college offered various courses to support patients to build skills in a range of areas, including self-management, communication, team working, emotional intelligence and problem solving. Some patients who had been discharged came back to share their experiences. This offered patients who were still in hospital opportunities to learn through the experiences of others.

Course subjects included internet safety, interviewing skills, food hygiene and catering, and chairing meetings. The provider held a graduation ceremony and patients received a certificate on completing a course. Some had completed vocational qualifications such as horticulture and catering.

Meeting the needs of all patients

The service valued diversity. Care and treatment was accessible to all who needed it and took account of patients' individual needs. Staff made every effort to ensure that services, buildings and facilities were accessible to all whatever their disability, and that all patients received equitable treatment.

There was a proactive approach to understanding the needs and preferences of different groups and to delivering care in a way that met those needs, was accessible and promoted equality. This included patients with protected characteristics under the Equality Act, patients approaching the end of their life, and patients in vulnerable circumstances or who had complex needs. Staff made reasonable adjustments and took action to remove barriers when patients found it hard to use or access services. For example, when patients were fasting for religious reasons, they adjusted times when food was available to meet the patients' needs.

All staff received training on the Equality Act 2010. Some staff had completed 'train the trainer' training for lesbian, gay, bisexual, and transgender (LGBT) issues. There was an LGBT champion.

Staff assessed patient satisfaction with equality and diversity through patient discussions at community meetings, ward rounds, care programme approach meetings, quality walk rounds and the complaints procedure.

Information leaflets were available in a range of languages and formats. Interpreters were available for patients who needed them.

All the wards had an accessible shower and bedrooms identified for patients with mobility needs on the ground floor.

Staff helped patients with communication, advocacy and cultural support. There was information about the independent mental health advocacy service and how to contact the advocate.

There was a project about communication disorders designed to ensure an enabling environment. Staff attended learning disability and autism service line meetings and local autistic spectrum disorder access assessment team meetings, to ensure their practice was up to date and in line with best practice.

Staff supported patients' spiritual and religious needs. There was a dedicated multi-faith room for prayer in the grounds, with equipment related to different religions. Staff told us that they would facilitate all patients' religious and spiritual needs, preferably within the local community.

Care was tailored to meet the needs of individual patients and delivered in ways that ensured flexibility, choice and continuity of care. Patients' individual needs and preferences were central to the delivery of personalised services. Patients were involved in the design and delivery of services via the service user council.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs.

Care and treatment were co-ordinated with other services and other providers. This included liaising with families and carers and ensuring that all services were informed of any diverse needs that needed to be addressed.

The importance of flexibility, informed choice and continuity of care was reflected in the service. Patients' needs and preferences were considered and acted on to ensure that the service was delivered appropriately.

Activities included over-50s walking football and pet therapy. Patients had made willow sculptures in the woodland walk and developed a new garden layout. Some patients had been recruited as gardeners for real work opportunities. There was a patient choir and band that performed at external venues.

There was a range of information about treatment, safeguarding, patients' rights and complaints information. Information on mental health problems and medication was available and there were advice sheets about medication on the wards. Information was available in different accessible formats, such as easy read or braille, or in different languages, if required. Interpreters and signers were available if needed. Hawthorn used laminated placemats in the dining room that had a different theme every month, such as information about diabetes, in easy read format with colourful pictures and key facts. These had been well received by patients, who had helped to decide themes and develop them.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Staff used portion control to maintain a healthy diet. There were meal choices for vegan and halal diets and for patients who had allergies or medical conditions, such as diabetes. The menus incorporated a 'traffic light' system so that patients had nutritional information about food choices. The chef met with patients to discuss menus and requirements, and patients had nutritional information about food choices.

Listening to and learning from concerns and complaints

During the 12 months to 31 December 2018, the service received 36 complaints:

- Arkwright - 0
- Elmhurst - 9
- Kenton - 15
- Wainwright - 12

Seven complaints were upheld and three were partly upheld. None of the complaints were referred to the parliamentary and health services ombudsman.

Each ward kept a log of complaints. Informal complaints were resolved at ward level if possible. All complaints had been dealt with promptly.

During the same time period, 84 compliments were received.

Outstanding ☆

Forensic inpatient or secure wards

Patients knew how to complain or raise concerns. There were boxes in the patient areas for comments and suggestions. There was information about how to complain displayed on the wards. The complaints process was always followed whether patients complained formally or informally.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The service used learning from complaints and concerns as an opportunity for improvement.

All complaints were discussed at daily handover meetings and the senior managers' morning meeting. Following the investigation of a complaint, staff received feedback and any recommendations for improvements. Complaints outcomes were communicated to staff via team briefings and individual supervision. Any themes and lessons learnt were communicated throughout the organisation and addressed appropriately. This included lessons from complaints at other sites.

Patients were involved in reviewing complaints and how they were managed via the service user council. The service made improvements as a result of learning from reviews, and that learning was shared with other services.

Patients knew how to give feedback about their experiences, including how to raise any concerns or issues, and could do so in a range of accessible ways.

Patients, their family, friends and other carers felt confident that if they complained, they would be taken seriously and treated compassionately. They felt that their complaint or concern would be explored thoroughly and responded to in good time because the service dealt with complaints in an open and transparent way, with no negative repercussions.

Are forensic inpatient or secure wards well-led?

Outstanding ☆

Leadership

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

Managers had the right skills and abilities to run a service providing high-quality sustainable care.

There was compassionate, inclusive and effective leadership at all levels. This was sustained through a leadership strategy and development programme, effective selection, deployment and support processes, and succession planning.

Leaders demonstrated the high levels of experience, capacity and capability and integrity needed to deliver excellent and sustainable care. Leaders at every level were visible and approachable for patients and staff.

There was an established system of leadership development and succession planning, which aimed to ensure that the leadership represented the diversity of the workforce.

There were comprehensive and successful leadership strategies to ensure and sustain delivery and to develop the desired culture.

Leaders had a deep understanding of issues, challenges and priorities for quality and sustainability in their service, and the wider community. They understood what the risks to performance were and they acted to address them.

Vision and strategy

The provider had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a clear statement of vision and values, driven by quality and sustainability. It was translated into a robust and realistic strategy and well-defined objectives that were achievable and relevant.

The strategy was developed through a structured planning process in collaboration with patients, staff and external partners. It was aligned to local plans in the wider health and social care economy and services were planned to meet patients' needs.

The values were:

1. We put safety first

2. We put the people we care for at the centre of everything we do

3. We take pride in what we do and celebrate success

4. We value our people

5. Your voice matters

The purpose was to make a real and lasting difference for everyone the service supported. There was a common focus on good care.

Leaders actively promoted the values and behaviours to ensure staff understood them. A copy of the values and behaviours was sent to every employee in the company with their wage slips. Posters were displayed across site and there were 'credit cards' for staff detailing the values and expected behaviours. The provider's values and expected behaviours had also been integrated into the care certificate workbooks, and were actively promoted on the intranet. During the recruitment process, the corporate provider behaviours informed the selection process to ensure that candidates understood the required standards.

In addition, there were quality assurance processes that ensured the care provided was good. Where improvements were required, staff took appropriate action in a timely manner, in line with the values and behaviours. This included quality walk rounds, which formed part of the clinical governance policy. The walk rounds were conducted by members of the management team, regional quality improvement leads, and staff and service users. The outcomes of the walk rounds were collated and actions followed up and disseminated. The values were also integrated into everyday business via team meetings, lessons learned and handover meetings.

The vision and values were embedded in the service and in individual practice. Staff knew and supported the vision, values and strategic goals and understood how their role helped in achieving them. At each supervision session, staff were expected to demonstrate how the vision and values were integrated into their practice.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were implemented consistently and had a positive impact on quality and sustainability of services.

There were measurable outcomes that supported the strategy. Staff understood the challenges to achieving the strategy, including relevant local health economy factors, and there was an action plan and they had opportunities to contribute to discussions about the strategy.

Culture

There was a highly positive, transparent and person-centred culture across the location. The leadership was inspiring and proactive in guiding others to achieve successful outcomes for patients, and this clear commitment was replicated throughout the hospital site.

There was a huge commitment to recovery at all levels. Staff were highly motivated for patients to be discharged. There was a great emphasis on supporting patients to develop and build the skills they needed to live independently in the community.

Staff encouraged patients to become part of the wider community by participating in opportunities away from the hospital site.

Staff were committed to encouraging patient involvement. Patients were involved in the service at all levels, including governance.

Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff felt respected, supported and valued. They were proud of the organisation as a place to work and spoke highly of the culture.

There were high levels of satisfaction among staff, including those with protected characteristics under the Equality Act. There was a strong organisational commitment towards ensuring equality and inclusion across the workforce. Leaders actively promoted equality and diversity. The causes of any workforce inequality were identified and action taken.

Staff felt able to raise concerns without fear of retribution. They were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this. Candour, openness, honesty, transparency and challenges to poor practice were typical. Leaders actively promoted staff empowerment to drive improvement. Raising concerns was encouraged and valued. Staff actively raised concerns and when they did they were supported. Managers investigated concerns sensitively and confidentially, and they acted on lessons learned and shared them. Staff understood what a notifiable safety incident was and what they were expected to do. When something went wrong, patients received a sincere and timely apology and staff told them about any actions being taken to prevent the same happening again.

Outstanding ☆

Forensic inpatient or secure wards

There was strong collaboration, team-working and support and a common focus on improving the quality and sustainability of care and people's experiences. Leaders encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. There were processes and initiatives to support staff and promote their positive wellbeing. Staff success was recognised through staff awards. The recovery team had won the provider's 'Pride' award for their work.

There was a culture of collective responsibility between teams and services. There were positive relationships between staff and teams, where conflicts were resolved quickly and constructively and responsibility shared. There were processes for providing all staff with the development they needed, including high-quality appraisal and career development conversations.

Leaders promoted shared values, prioritised high-quality, sustainable and compassionate care, and promoted equality and diversity. They encouraged pride and positivity in the organisation and focused attention on the needs and experiences of patients. Behaviour and performance inconsistent with the vision and values was identified and dealt with swiftly and effectively, regardless of seniority.

Governance

There was a systematic approach to continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish, and working with other organisations to improve care outcomes.

There were clear governance systems that ensured oversight of the service. There was a 'ward to board' model of governance. Staff were encouraged and supported to be involved in the governance process. Patients were involved in governance at all levels. Governance arrangements were reviewed proactively and reflected best practice.

All levels of governance functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

There was a clear framework of what was to be discussed at ward, team or directorate level to ensure that essential information, such as safeguarding information, and learning from incidents and complaints, was shared and discussed. All policies were reviewed regularly and updated. The service user council was represented at governance meetings. Meeting minutes were structured and informative, clearly addressing quality issues.

CQC's Mental Health Act reviewer reports were reviewed. Senior managers were aware that any required action had been taken to address identified issues. Statistical information on the operation of the Act was monitored. Statistical information on patterns of admission and length of stay was considered and compared with national data. Mental Health Act documentation and compliance was overseen and reported on by the Mental Health Act administrator.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts.

Staff participated in local clinical audits, such as audits of care records, environmental audits and audits of infection control systems. The audits were monitored via electronic quality dashboards. They were sufficient to provide assurance and staff acted on the results when needed.

Quality and safety were monitored via electronic dashboards. Quality performance indicators were monitored and reported on every month.

Annual quality improvement objectives were set and clinical audits conducted. The information was collated and an audit report disseminated. Objectives included undertaking a literature review to look at patient motivation, and the introduction of a protocol to support behavioural activation, and positive behavioural interventions using the clinical intervention of positive thinking training.

Management of risk, issues and performance

There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. Staff maintained and had access to the risk register at ward level. They could escalate concerns if they needed to. There was an overarching strategic risk register at board level.

There were plans for managing identified emergencies such as the premises becoming not fit for purpose, adverse

weather or an outbreak of illness. Other identified risks included staff retention, breakdown of key customer relationships and information technology failure. There were controls in place to mitigate the likelihood and impact of all identified risks.

There were processes to manage current and future performance. There was a demonstrated commitment to best practice performance and risk management systems and processes.

The provider reviewed how the service functioned and ensured that staff at all levels had the skills and knowledge to use systems and processes effectively. Problems were identified and addressed quickly and openly. There was a clear 'no blame' culture, whereby no individual was deemed responsible. When something went wrong, the service looked at why and how the system had gone wrong, what steps were needed to rectify that, and took those steps.

Performance issues were escalated appropriately through clear structures and processes. Clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns.

Where cost improvements were taking place, they did not compromise patient care. Financial pressures were managed so that they did not compromise the quality of care. Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care was understood.

Information management

The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The provider invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was consistently accurate, valid, reliable, timely and relevant.

There was an holistic understanding of performance, which included quality, operational and financial information. Quality and sustainability both received good coverage in relevant meetings at all levels.

There was commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The data they received supported them to adjust and improve performance as necessary. Performance information was used to hold management and staff to account.

Staff had access to the equipment and information technology they needed. The information technology infrastructure worked well. Integrated reporting supported effective decision making and helped to improve the quality of care. The systems to manage and share the information needed to deliver effective care treatment and support were co-ordinated and supported integrated care for patients. Information governance systems protected confidentiality of patient records.

Data or notifications were consistently submitted to external organisations as required. There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems were used effectively to monitor and improve the quality of care.

Engagement

Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. They actively shaped the culture through consistently high levels of constructive and effective engagement with staff, patients and carers, including all equality groups, and external stakeholders such as commissioners. They welcomed rigorous and constructive challenge and saw it as a vital way of holding the service to account. They were committed to promoting engagement to increase the chances of achieving better outcomes, both business and patient focussed.

Services were developed with the full involvement of patients, staff and external partners, as equal partners. There was a demonstrated commitment to acting on feedback. The service proactively engaged and involved all patients and staff, including those in different equality groups, so that a full and diverse range of views and concerns was encouraged, heard and acted on to shape the service and culture.

The provider was transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the patient group, and to design improvements to meet them.

Patients and carers were involved in decision-making about changes. They had opportunities to give feedback on the service in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

There were annual staff surveys that showed high levels of satisfaction, with action plans for improvements based on the findings. For example, 18% of staff overall did not respond to the survey and there was an action plan to capture this missed population as part of the 2019 employee engagement strategy. Changes made because of the survey findings included increased flexible working applications being supported, access to line managers being facilitated to agree career pathways and complete annual appraisal, introduction of a night allowance, and increased profile of the 'working well' group and its staff wellbeing activities.

The employee engagement strategy for 2019 built on the issues raised by staff via a variety of forums, including the established open door policy across site, 'your say' forum, staff meetings and staff surveys.

All staff were enrolled on a career pathway. Some health care support staff had been supported through training to become registered nurses. All staff had opportunities to be seconded to other services.

There was an established 'working well' initiative to promote staff retention and reduce sickness rates. Staff had presented this at a Royal College of Psychiatristsevent and the initiative was a Nursing Times awards finalist. Funds were raised via 'dress down' days and 'bacon butty' days, then used to hold a staff event with prizes, massage and relaxation sessions, and breakfasts for staff being delivered to wards. Other support for staff included increased flexible working arrangements, which could be for various reasons such as to attend college or to care for children or other relatives.

Staff were proud of the organisation and the positive culture. They felt respected, valued and supported, and they were committed to providing quality care.

Learning, continuous improvement and innovation

There was a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

There was a fully embedded and systematic approach to improvement, which made consistent use of improvement methodology. Improvement was viewed as the way to deal with performance and for the organisation to learn.

Improvement methods and skills were used across the organisation. There were organisational systems to support improvement and innovation work, including staff objectives and rewards, and staff were empowered to share improvement work, and to lead and deliver change. Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work locally and nationally.

The service made effective use of internal and external reviews, and learning was shared effectively and used to make improvements. Staff were encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. They were supported to consider opportunities for improvements and innovation and this led to changes. For example, they had implemented the use of new assessment tools and outcomes measures, and had reviewed the implementation of the 'safe wards' model of care supported by the 'reinforce appropriate, implode disruptive' positive psychology approach.

Staff participated in national audits relevant to the service and learned from them.

Staff had opportunities to engage in research. The low secure service had recently undertaken two research initiatives. They used the findings to improve care.

The service participated in relevant accreditation schemes and learned from them. The low secure service was an established member of the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

Safe	Outstanding ☆
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are long stay or rehabilitation mental health wards for working-age adults safe?

Outstanding ☆

Safe and clean environment

All the wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

There were spacious communal rooms, activity areas and kitchens. There was a lounge and separate dining room that patients had access to throughout the day. Patients were able to make their own drinks and snacks whenever they wanted. There were further quiet rooms and visiting rooms. Cleaning records were complete and up-to-date. The furniture appeared comfortable and most was in good order. However, on Oakwood ward, some of the sofas in the games room area were ripped on the arms and needed replacing. New sofas had been ordered to replace those that were damaged.

Patients all had their own en-suite bedrooms. The bedrooms were spacious and had a lockable space for personal items. There were nurse call alarms next to each bed. There were additional showers and bathrooms. Bathrooms were clean and tidy.

The service only admitted male patients, so all wards complied with Department of Health guidance on the elimination of mixed sex accommodation.

As part of the recovery programme, patients who were able to keep their own bedrooms clean were encouraged and supported to do so by staff.

The ward décor was bright and well maintained.

The ward managers told us that staff had worked with patients to look at what pictures they wanted on the ward instead of buying generic ones. Patients had identified local areas they liked, such as woodland and streams, and had taken photographs of them. The staff had then arranged to have the photographs transferred onto canvases, which were displayed around the ward.

The layout of the wards did not allow clear lines of sight throughout but risks were mitigated by using mirrors, observation and staff presence, staff awareness, care planning, individual risk assessments and levels of observation, and good relational security.

These measures ensured staff could monitor all areas of the wards. They carried out regular risk assessments of the care environment that included blind spots and external areas, and they knew about potential ligature anchor points and actions to mitigate risks to patients who might try to harm themselves. For example, bedrooms were fitted with anti-ligature wardrobes and fixtures and fittings, such as collapsible curtain rails.

There were red, amber and green rated floor maps displayed in the staff rooms that identified high risk areas at a glance, although they did not provide the level of detail the risk assessments did.

There were some identified potential ligature points in the laundry room on the rehabilitation wards. The ward managers told us that as they were promoting independence, the laundry room was left unlocked so patients could access it at any time.

On Oakwood ward, it took some time to find the environmental risk assessments as the staff member showing us around did not know where they were stored. However, all staff were familiar with the location of ligature anchor points.

Staff had easy access to alarms and patients had easy access to nurse call systems. The ward doors were locked and staff, patients and visitors entered and left the wards via an airlock. Patients who had appropriate leave used the airlock without a staff escort.

The door access system operated in conjunction with a key tracker system that blocked the exit if a key holder tried to leave before returning their keys. All staff understood the safe management of keys.

Staff had personal alarms to call for assistance if there was an emergency. The alarms were linked to a hospital wide system. There were designated staff on each shift who responded to incidents on other wards.

Security was grounded in staff knowledge and understanding of their patients. Relational security was well embedded. Staff understood the significance of building trust, setting and maintaining boundaries and understanding the patient group dynamic to ensure there was an appropriate balance between restriction and a caring environment.

All the wards had secure garden areas. There were written protocols on each ward for access to the garden areas. Patients' views had informed the protocols. Patients generally had unsupervised access during daylight hours, depending on individual risk assessment, which was reviewed if individual patients' risks or safety changed. Security checks were completed before the gardens were used, and randomly four times every hour after that. Patients who had appropriate leave could also access other outdoor areas across the site.

The rehabilitation wards did not have seclusion rooms. Hawthorn ward had a low stimulus room which had recently opened. This room was used to assist with de-escalation. Patients could use the room at any time and could leave when they wanted to. Patients had been involved in decorating and choosing the artwork. The room had two large bean bags and a weighted sofa. Staff stayed with any patients who needed to use the room. The manager told us that some patients chose to use the room when they were feeling distressed or anxious on the ward and wanted time away from the hustle and bustle of the ward. The door was kept locked but patients could access it through staff at any time. The manager told us that originally it had been kept open but they found that sometimes when a patient needed to use it, it was already occupied by another patient who preferred to be in the room and they would refuse to leave it. This prompted the decision to lock it so it could be available for patients who had a clinical need to use it.

Oakwood ward did not have a dedicated low stimulus room but had beanbags that could be taken into the visitors' room in situations where a patient needed a low stimulus environment.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

The service provided locked storage for each patient to store any valuable possessions they had. Any banned items, such as cigarettes and lighters, were kept securely by staff.

The atmosphere on the wards was relaxed. Patients conversed openly with staff and the inspection team. They were comfortable in the presence of staff. Many of the patients were off the ward doing various individual and group activities with staff or on unescorted leave periods. None of the patients we spoke with complained of boredom.

In the entrance to the wards, there were notice boards with staff photos. There were also boards in the corridors that showed all the birthdays of staff and patients, activities they enjoyed and key dates for the month in an easy read visual format.

Safe staffing

There were enough nursing and medical staff, who knew the patients and received training to keep people safe from avoidable harm. Managers ensured each shift had appropriate numbers of staff with the right skills. Staffing ratios were in accordance with best practice guidance.

The wards operated to an agreed staffing ladder made up of qualified nurses and healthcare workers. The staffing ladder calculated the number of each discipline required to safely staff the ward for the number of current patients. Patients requiring escorts and constant nursing observation and engagement support sat outside the

ladder and additional staff were brought in to fulfil those duties. Staffing was increased when required. Ward managers met with the director of clinical services every day to review staffing. Additional staff requirements were supported as clinical needs dictated so that patient care remained safe. Out of hours staffing needs were monitored by the site co-ordinator and staffing concerns could be escalated via the provider's established process, providing support as needed from senior managers and access to staff across the region.

Across the site there were no registered nurse vacancies and 18.9 nursing assistant vacancies out of 116 whole time equivalent posts.

From January to December 2018, the sickness rate was 2.4% across the hospital site.

When necessary, managers used bank nursing staff to maintain safe staffing levels. There was a pool of bank staff who completed regular shifts. They could book shifts using a text system that had been developed internally. All bank staff completed a comprehensive induction prior to attending the wards. They were also offered training opportunities, dedicated weekend training days, attendance at wellbeing events and clinical supervision to ensure they felt engaged as part of the staffing establishment.

There was a preferred supplier list of agency staff, which entailed strict agency worker competencies and governance arrangements. Agency staff would receive a local induction checklist and be supervised.

In the three months from October to December 2018, the following shifts had been filled by bank staff:

- Hawthorn - 104
- Oakwood - 60

No shifts were unfilled. No agency staff had been used.

A qualified nurse was present in communal areas of the ward at all times.

Staffing levels allowed patients to have regular one-to-one time with their named nurse.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training included immediate life support for all registered nurses and doctors, and basic life support for all other staff. Other modules included infection control, cyber security, data protection, moving and handling, and safeguarding. Mandatory training for managers included leading health and safety. Managers monitored compliance via an electronic system that alerted them when refresher training was due. Staff could also access the online system and they received protected time to complete mandatory training. The system was interactive and staff could monitor their own training and ensure they kept up to date.

Most staff had received and were up to date with appropriate mandatory training:

- Oakwood - 98%
- Hawthorn - 98%

All mandatory training modules had a compliance rate of 95% or above. The site learning administrator provided regular updates and reminders to line managers, and reported to the hospital governance group if specific modules started to fall, or did fall below the compliance target of 90%.

There were options for learning, such as classroom sessions interactive e-learning followed by an e-assessment to ensure competence. There was also an audit process that randomly checked staffs' knowledge.

Assessing and managing risk to patients and staff

The rehabilitation service provided specialist forensic rehabilitation for patients stepping down from a higher level of security. The focus was on the patient's forensic risks, providing a safe transition to community living.

We reviewed seven care records.

Staff took a proactive approach to anticipating and managing risks to patients. All staff recognised their responsibility in this. Records we reviewed showed that staff were able to discuss risk effectively with patients. For example, there was discussion about substance misuse, self neglect, sexual vulnerability, possible public protection issues and reasons for enhanced observation. The multi-disciplinary team completed a pre-admission assessment and on admission all patients had an initial care plan that included identified risks.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

Staff used recognised risk assessment tools, such as the historical clinical risk management tool (HCR-20), which assesses the patient's risk of violence in the present and future, and the short-termassessmentof risk and treatability, an assessmentof short-term risk for violence, to inform over-arching risk management plans.

The rehabilitation wards had recently implemented use of the Camberwell assessment of need short appraisal schedule. The aim of the tool is to identify patients' needs, so it can be a part of routine clinical practice and research, as well as a component of service evaluation.

Staff completed and updated risk assessments for each patient and used them to understand and manage risks individually. Risk management plans addressed all identified risks. Patients were involved in identifying their own risks.

Staff assessed, monitored and managed risk to patients on a day-to-day basis. They were aware of and dealt with specific risk issues, such as substance misuse, potentially risky behaviours or physical health issues. They identified and responded to changing risks to, or posed by, patients. Risk assessments and management plans were person-centred, proportionate and reviewed regularly at least every four weeks or when there was clinical need. Patients and those close to them were actively involved in managing their own risks.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.

Where environmental risks had been identified, there were measures to manage them. For example, following the engagement and observation policy, ensuring robust risk management plans for all patients, and management of the environment.

Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Any staff shortages were addressed quickly and adequately.

Staff recognised and responded appropriately to changes in the risks to patients. There were effective handovers and shift changes to ensure that staff understood and could manage risks to patients. Staff understood the significance of developing trust, setting and maintaining boundaries and understanding the patient group dynamic. They understood how to keep patients safe from avoidable harm and provide high quality care.

Staff were trained in prevention and management of violence and aggression, including de-escalation techniques. The service did not use prone restraint techniques.

Staff also used 'reinforce appropriate, implode disruptive' (RAID) techniques. RAID uses positive behaviour reinforcement to reduce potentially violent situations. All staff including housekeepers and other ancillary staff were involved in using the technique. RAID training is provided by the Association for Psychological Therapies.

From January to December 2018, there had only been one serious incident recorded that involved violence.

The wards participated in the provider's restrictive practice programme. There was a reducing restrictive practice steering group, membership of which included clinicians and staff who delivered prevention and management of violence and aggression training. There was a reducing restrictive practice strategy. The provider had participated in the NHS England Commissioning for Quality and Innovation framework for the last three years and met all of the indicators in each quarter. The 'safe wards' initiative had been introduced into prevention and management of violence and aggression training. This was part of a project agreed with NHS England to focus on positive and proactive care. The 'safe wards' initiative focuses on soft words, de-escalation, and positive words as well as key aspects concerning positive behavioural support plans. These included behaviours rated as red, amber or green, why they might happen, what might help and how to respond. There was also a training module for clinical staff on positive behavioural support.

Staff minimised their use of restrictive interventions. They followed best practice and the Mental Health Act when restricting patients' freedoms to keep them and others safe. They applied blanket restrictions only when justified.

Hawthorn ward had a low stimulus room, and we were told that using the room had helped to reduce the levels of restraint and seclusion.

There was a pattern of reduction in use of some forms of restrictive intervention. In the 12 months leading up to this

inspection, compared with the previous 12 months, incidents of seclusion had reduced from six to four, of restraint from 55 (with nine in the prone position) to 16 (with none in the prone position), and of rapid tranquilisation from 18 (involving three patients) to three (involving one patient).

No patients were nursed in long term segregation in the two years before this inspection.

Following learning shared from another site, the provider had introduced monthly audits of the use of rapid tranquilisation and the service took part in this. Lessons learned were that when physical observations were omitted due to presenting risks, this should be clearly documented in the patient's care notes and staff should document their observations of the patient's colour, pallor and overall presentation, such as how alert and orientated they were.

The numbers of incidents involving restraint was a quality performance indicator, which was monitored through the clinical governance structure. Themes, trends, lessons learned and positive practice from the use of prevention and management of violence and aggression were shared across the wards. There was a feedback survey for patients who had required the use of prevention and management of violence and aggression. Feedback was used to inform positive behaviour support plans and improve practice, and the provider had invested in specially designed bean bags that maintained the body angle at 135 degrees, which optimised chest expansion and lung function, and minimised head trauma during restraint.

The bean bags were developed for use in healthcare environments in response to changes in guidance and trying to reduce prone restraint due to risk to the patient and staff. They have been medically risk assessed and clinically approved by a member of the Royal College of emergency medicine and Royal College of surgeons.

Staff were trained to use the bean bags as part of prevention and management of violence and aggression training. Trainers were trained in their use and the safety rationale, and had annual trainer refresher courses, plus access to video sessions to refresh their learning. The provider's policy on the prevention and management of disturbed and violent behaviour provided guidance for staff.

Physical interventions were no different to how the provider trained staff when sitting a patient in a seat as the same techniques applied. However, the bean bags were easy to move so staff could manoeuvre the bean bag to the patient rather than having to move the patient. This reduced the likelihood of injury to both staff and patients and reduced moving and handling issues.

Since introducing the bean bags, there had been no use of prone restraint in this core service. Patients reported better satisfaction with the introduction of the bean bags.

The provider explained how using the bean bag had been effective in the second of two incidences of seclusion that involved the same patient, reducing the time of restraint and the use of prone restraint.

In the first incident, prolonged restraint and attempts to leave the seclusion room lasted for almost two hours, with prone restraint being required along with rapid tranquilisation. In the second incident, when the bean bag was used, staff were able to exit immediately and no prone restraint or rapid tranquilisation was needed. The multi-disciplinary team seclusion review stated that the patient appeared much calmer and reported no injuries or physical distress.

Staff understood the Mental Capacity Act definition of restraint and where appropriate they worked within it.

There was a clear culture of positive risk taking and least restrictive practice. Wards had a 'least restrictive practice' champion who provided advice and support to other staff and distributed information. Many patients had ground or community leave. Devices with connectivity were the norm. Patients had access to a range of 'real work' opportunities, both on-site and in the community. Staff used technology that selected at random patients to be searched following leave.

Access to potentially risky items was continually reviewed and controlled appropriately. Access to items such as razors was individually risk assessed and monitored. The service had worked with patients to reduce the restrictive practices around technology. Based on individual risk assessments, some patients were allowed their smart phone on the wards and their own computers in their bedrooms. There was a 'devices with connectivity' policy to ensure this was managed properly. The recovery college offered training for ensuring safety online for patients.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

Self-harming behaviours comprised one of the highest rates of incidents. As part of the management of self-harming behaviour, the service had implemented various levels of observations dependent on each patient's assessed risk and management plan. All patients were engaged in developing their 'keeping safe' care plan whereby taking responsibility was encouraged and facilitated.

All patients had crisis plans that set out how they preferred to be cared for in the event of a crisis, which included if an identified risk occurred.

Staff used seclusion appropriately and followed best practice when they did so. They kept appropriate records for seclusion.

The hospital only admitted patients detained under the Mental Health Act 1983; however, sometimes patients already in hospital were discharged from detention under the Act. There was a policy to guide staff in managing these patients, and an information leaflet for patients.

Safeguarding

Staff knew how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Patients were at the centre of safeguarding and protection from discrimination. There were comprehensive systems to keep people safe, which reflected current best practice and addressed patients' diverse needs. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The whole team was engaged in reviewing and improving safety and safeguarding systems. Leaders encouraged innovation to achieve sustained improvements in safety and continual reductions in harm. For example, there were monthly meetings with the local safeguarding hub to review all incidents and share lessons learnt. This had enabled 95% of safeguarding concerns to be closed.

There was a safeguarding policy and procedures for staff guidance, and safeguarding information was displayed on the wards. There was a safeguarding lead on the hospital site, and social workers also provided guidance.

Staff had received up-to-date training in all safety systems, processes and practices. Training included 'bite size' refreshers on various topics, such as self neglect, and sexual contact between patients.

Staff knew how to recognise and report abuse. They were encouraged to speak up and took a proactive approach to safeguarding, focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including patients, to agree and implement protection plans. Staff ID cards had whistle blowing information and phone numbers for concern lines on them.

There was active and appropriate engagement in local safeguarding procedures and effective partnership work with other relevant organisations, such as the local safeguarding authority. The partnership included involvement in managing concerns about people in positions of trust, whereby concerns raised about staff would be alerted to the hospital.

There were safe procedures for children visiting. Visits by children took place away from the ward.

Staff reported safeguarding events appropriately, including patient on patient and patient on staff assaults.

Staff access to essential information

Care records were stored electronically. Paper records, such as Mental Health Act documentation, were stored securely. They were also scanned onto the electronic system so that they were available to all staff when needed. Access was protected to ensure the records remained secure.

There were hard copies of records such as current observations records, which were scanned onto the electronic system once completed.

Staff maintained high quality clinical records of patients' care and treatment. They had protected time to complete documentation to ensure it was current. Records were accessible, clear and up-to-date. Each contained a one page profile of the patient so staff had quick, easy access to current, relevant information.

The systems to manage and share the information needed to deliver effective care treatment and support were

co-ordinated and supported integrated care for patients. Staff could access the information they needed to assess, plan and deliver care, treatment and support to patients in a timely way.

Staff ensured that patients could transfer seamlessly between services because they shared information between teams and planned ahead. Patients understood the information being shared about them and had a copy if they wanted one. Staff involved partner agencies and carers when sharing information. They ensured that their practice supported accurate and personalised information sharing; for example, care co-ordinators could attend meetings via online conferencing facilities.

Medicines management

Staff met good practice standards described in relevant national guidance. They managed medicines consistently and safely. Medicines were stored correctly, and disposed of safely. Staff kept accurate records of medicines. Medicines reconciliation was carried out every week.

Staff regularly reviewed the effects of medications on each patient's physical health. Patients were involved in their medicines reviews.

We visited the clinic rooms where medicines were stored and looked at medicine records for 12 patients.

When required, prescribing complied with the requirements of the Mental Health Act. Prescriptions were clinically checked by the pharmacist contracted by the hospital. The governance arrangements for controlled drugs were appropriate.

Staff followed best practice when storing, administering and recording medicines. Compliance with medicines policy and procedure was monitored routinely and action plans implemented promptly. Ward managers and the pharmacist audited the use of medicines on a regular basis to identify any concerns and ensure medicines use was safe and responsive.

We found no evidence that any medicines were being used excessively or inappropriately to control behaviour.

However, on Oakwood ward staff were not following the provider's process when supplying medicines to two patients who were self-medicating, in that staff were dispensing their medicines from stock. The registered manager took immediate action to rectify this situation.

We were assured patients were safe before the inspection was completed. The provider's response addressed not only the immediate issue but the wider hospital community, to ensure the issue did not arise again elsewhere. Further, there was a clear 'no blame' culture, whereby no individual was deemed responsible. The response looked at why and how the system had gone wrong, what steps were needed to rectify that, and took those steps.

Following our feedback a check on medicines that patients were self-administering was added to the established audits.

Staff regularly reviewed the effects of medicines prescribed for mental health needs on patients' physical health. The use of medicines to treat violent or aggressive behaviour was audited to check that physical observations necessary to ensure the patient's safety were carried out.

In addition to the established audits, the provider was in the process of completing a high dose anti-psychotic drug audit, using the Maudsley national monitoring guidance.

Mental Health Act compliance and administration errors were highlighted through audit. To reduce errors, a staff education leaflet had been produced, the weekly clinic audit document altered and Mental Health Act documents reviewed in each ward round to improve Mental Health Act compliance.

Staff education also included attendance at relevant medication management training, completion of a medication management workbook, and having opportunity to reflect on and develop skills in medication management.

Track record on safety

The service had a sustained track record of safety supported by accurate performance information. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety. There was ongoing, consistent progress towards safety goals.

From January 2018 to December 2018, there had been seven recorded serious incidents in the rehabilitation service:

- Hawthorn - 5
- Oakwood - 2

These comprised:

- Inappropriate sexualised behaviour - 3
- Aggressive behaviour - 1
- Absent without leave from unescorted leave - 2
- Expected death - 1

Two of the seven incidents had occurred in the six months before we inspected. All the incidents had been investigated.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff at all levels were open and transparent. They recognised incidents and reported them appropriately. They understood their responsibilities to raise concerns and report incidents and near misses and were fully supported to do so.

It was recognised that incidents were distressing for patients, staff and professionals involved and the importance of how discussing incidents promptly and compassionately helped reduce the potential impact. Following serious incidents, staff and patients received de-briefing that incorporated support and reflective discussion and input from a psychologist. Incidents were also discussed in clinical supervision, team incident reviews and staff meetings. Staff also discussed any incidents with patients, their families (with their consent), carers and other professionals involved in their care.

There was a genuinely open culture in which safety concerns raised by staff and patients were considered fundamental to learning and improvement. All incidents fed into daily managers' meetings and were discussed at handover and in reflective practice meetings. Where necessary, incidents were escalated for further investigation. The monthly clinical governance committee meetings had oversight. Where action points and recommendations were made these were followed up in weekly senior management team operational meetings. Staff also had discussions with patients about their management preferences.

Learning was based on analysis and investigation of things that went wrong, that involved all relevant staff, partner organisations and patients. Lessons learned were communicated widely to support improvement in other areas as well as services directly affected. All staff were encouraged to participate in learning to improve safety as much as possible, including working with others in the system.

Immediate lessons learnt were shared via the site co-ordinator across all the wards and departments. Incidents data was collated monthly for themes and shared via publications, briefings, incident review reports and ward planning and development meetings. Learning was also accessed via the service intranet.

The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality. Staff understood the duty of candour. When things went wrong, they apologised and gave patients honest information and suitable support.

We saw evidence of learning and improvements to safety being made following incidents; for example, engaging patients to be fully involved in their care planning processes, addressing the 'keeping safe' component where responsibility is encouraged and facilitated, the introduction of specially designed bean bags for use in restraint, and facilitating dialectical behaviour therapy skills training for ward teams.

The service monitored changes made through looking at trends, quality walk rounds, supervision and audit.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Outstanding ☆

Assessment of needs and planning of care

We reviewed seven care records.

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.

There was a holistic approach to assessing, planning and delivering care and treatment, supported by evidence based practice. Leaders actively encouraged the safe use of

innovative approaches to care and how it was delivered, such as implementing new assessment tools and outcomes measures, and utilising research findings to make improvements.

Patients all had comprehensive assessments of their needs, which included consideration of their clinical needs including pain relief, mental health, physical health and wellbeing, and nutrition and hydration needs. Assessments focused on patients' strengths, self-awareness and support systems.

Care plans were holistic, personalised and recovery-oriented, and demonstrated staff's understanding of current, evidence-based practice.

Care planning was strongly focussed on the discharge pathway and what patients needed to achieve in order to be ready for discharge. Staff used a simple diagrammatic tool that provided patients with a visual summary of their discharge pathway. Discharge planning was fundamental to patients' care programme approach reviews, which were held every six months.

They focused on recovery in terms of relapse prevention, early warning signs, reducing self-harm, and developing individual support systems. Care plans identified outcomes for each identified need and the pharmacological, psychological and therapeutic interventions needed to achieve the outcomes.

Patients and staff identified expected outcomes together, and they regularly reviewed and updated care plans together. There were clear care pathways and appropriate referrals to make sure that needs were addressed. Staff recorded and monitored information about patients' care and treatment and outcomes.

Patients and staff had regular sessions to review their care needs, and they attended review meetings with the multi-disciplinary team. Families and carers were encouraged to be involved. Care co-ordinators were invited and could attend via online conferencing facilities.

Best practice in treatment and care

Staff planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice, legislation and technologies. They implemented evidence-based guidance in their clinical practice; for example, relating to risk management, aggression and violence, and schizophrenia, and when making prescribing decisions. Care plans also referenced national guidance.

Staff monitored their practice to ensure consistency. The supervision records we reviewed confirmed that staff were using national guidelines, for example, in relation to risk management.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). Interventions included medication, psychological therapies and activities, and training and work opportunities intended to help patients acquire living skills. Invasive interventions such as restraint and rapid tranquilisation followed best practice. There was a policy to provide guidance for staff and clear documentation in care records to explained why these interventions were necessary.

The provider monitored the NICE website for relevant new or updated guidelines and quality standards. When new guidelines were published, a summary of the main points and requirements, together with a link to the relevant pages of the NICE website and the full guidelines was disseminated throughout the wider hospital team.

A spreadsheet of current NICE guidelines and quality standards was accessible to all staff via the intranet. The spreadsheet provided a summary and a link to the full guidelines.

There was a clinical network structure that met every quarter to discuss, share and monitor best practice, including reviewing and implementing NICE and national guidelines as appropriate. For example, the NICE guidelines for suicide and learning disability had been reviewed, and a full action plan undertaken to ensure compliance.

A team of psychologists delivered a comprehensive programme of therapeutic interventions. Sessions took place in groups and one-to-one personalised programmes. Patients could refer themselves for therapies or the multi-disciplinary team could make a referral.

Interventions were evidence-based and recovery focused. They included motivational cognitive behaviour therapy techniques, group work skills, a 'life minus violence'

enhanced programme, sexual behaviour management, mastering a 'skill of the week', a responsible living group, emotional regulation, mindfulness, substance misuse awareness, dialectical behaviour therapy and cognitive behavioural therapyapproaches that emphasised consequential thinking. Patients were involved in developing their own treatment programmes.

The dialectical behaviour therapy team had won the Association for Psychological Therapies (APT) award for excellence, judged against criteria of excellence and likelihood to inspire others. This was the fourth APT award that the team had won in the last three years.

The provider also offered 'recovery college' courses to improve patients' health and wellbeing and provide education and skills development opportunities. This was in partnership with local colleges. A 'recovery college' is a course of workshops designed to increase awareness and understanding of recovery and what it means to each individual. Patients were involved in producing and facilitating courses.

The occupational therapy team had a specific focus on developing functional skills. These included promoting independence in personal care tasks, developing optimum skills in more complex tasks, such as managing a budget and engaging in work type occupations, and providing access to a range of community-based voluntary experiences, supported work and recreational activities.

The hospital site included a horticultural area, a woodland walk, a fitness suite and sports hall, including a badminton court, music facilities, an education suite, workshops for art and woodwork, a library, therapy rooms and social areas.

Staff also implemented 'reinforce appropriate, implode disruptive' (RAID) techniques across all therapies and activities. RAID uses positive behaviour reinforcement to deal with potentially violent situations. It is a recognised industry standard method of working with patients to help them manage their own behaviour. Since our last inspection, Kemple View had developed RAID across the site, and had maintained its accreditation as a RAID Centre of Excellence. Being recognised as a RAID Centre of Excellence means that that the organisation is implementing RAID principles outstandingly well, using a positive approach to interventions. The centre of excellence status is re-appraised at least every two years to ensure its current validity.

Wherever possible, information about patients' physical health was obtained before admission. On admission, patients were examined immediately or as soon as practically possible by the practice nurse or a doctor. A full assessment of their physical health needs was completed, which formed part of their mandatory 'keeping healthy' care plan, and repeated every quarter. Staff used the Lester tool to assess patients' physical health. Monitoring included blood tests, electrocardiograms and monitoring the side effects of medication.

Staff ensured a comprehensive 'keeping healthy' care plan was developed based on the patient's identified physical health needs, including sexual health, smoking, alcohol misuse, illicit substance misuse, weight, exercise and diet. This was completed as soon as possible by requesting any background and necessary information from the patient's GP and other relevant sources. Staff monitored and maintained patients' 'keeping healthy' care plans.

Staff monitored patients' ongoing physical health needs and all issues were discussed at ward reviews. All identified needs were comprehensively documented in the patient's physical health care plan, 'keeping healthy'. All care plans were reviewed monthly or following any clinical change to ensure each patient's physical health needs were met appropriately based on the evidence of relevant national guidelines.

There was an audit process to monitor patients' physical health assessments.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. A full-time practice nurse and a physical healthcare assistant were responsible for physical healthcare across the site. All patients had access to an on call doctor and weekly access to the visiting GP to ensure their physical health needs were met appropriately. There was also a monthly chronic illness management clinic held on site. This was part of the service level agreement with the local GP practice. Staff encouraged patients to access community based services, such as GPs and dental appointments.

The practice nurse carried out therapeutic drug monitoring for patients prescribed medicines such as clozapine, to

ensure their physical wellbeing. They also ensured patients had full written information before commencing the medication. Physical health monitoring following rapid tranquilisation was carried out routinely.

Staff were consistent in supporting people to live healthier lives, including identifying those who needed extra support, through a targeted and proactive approach to health promotion and prevention of ill-health, and they used every contact with patients to do so.

There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing. Patients had produced leaflets about the physical health strategy.

Staff offered health promotion activities to patients, such as walking groups, cycling, healthy eating, including 'fake away' nights where patients cooked a healthy meal together, access to the gym and men's health initiatives. Smoking and vaping was banned on site. Smoking cessation information was prominent on the wards. Nicotine replacement therapy was available and promoted. Staff educated patients about the effects of smoking on medication. Drinks and snacks in the café and shop on-site were sugar free and low fat wherever possible.

There was a weight management initiative called 'mission fit', facilitated by a fitness instructor who conducted an educational programme about healthy living and encouraged participation in exercise sessions. The programme targeted and catered for service users in a mental health care environment. Patients were challenged to lose 5% of their starting body weight over 12 weeks. The programme incorporated education about healthy living as well as taking part in exercise sessions. Since our last inspection, 'mission fit' had been developed so that after the first 12 weeks, patients were offered continued involvement to maintain their weight loss and to encourage healthy lifestyles.

This included group and individual sessions, healthy lifestyle advice, practical physical activity, advice on healthy eating, tackling motivation and identifying ways to get more active. This was supported with activity such as football, circuits, volleyball, hockey, badminton, gym and tennis. Staff and patients had completed the 'couch to 5k' initiative, a running plan for beginners. Mission fit also offered nutritional advice, ward based sessions, walking groups, boxercise, exercise challenges and twice weekly sessions for staff. 'Mission fit' also offered a service user a real work role and had trained them to plan, prepare and facilitate 'mission fit' sessions.

'Mission fit' also had links with the local community. Following sessions on site patients were offered community gym sessions and community boxing sessions. There were partnerships with two local gyms that patients could access. This created a pathway for establishing physical activity as a part of their recovery back into the community.

With the agreement of the multi-disciplinary team, patients could also take part in boxercise sessions, first on site and then in the community at a local gym. Patients were reminded about their behaviours while using the boxing equipment, that having the gloves was a privilege and that nothing learnt in sessions should be taken back to the wards.

Staff were actively engaged in activities to monitor and improve quality and outcomes. They routinely collected and monitored information about patients' care and treatment and their outcomes. They used nationally recognised assessment tools, such as the historical clinical risk management-20, the short-term assessment of risk and treatability and the health of the nation outcome scales.

The rehabilitation wards had recently implemented DIALOG, a patient reported outcome measure to support structured conversation between patients and staff that focuses on patients' views of quality of life, needs for care and treatment satisfaction.

Some patients were using DIALOG and the Camberwell assessment of need short appraisal schedule to measure their own progress.

Outcomes for patients were positive, consistent and met expectations. Staff shared information about effectiveness in multi-disciplinary team meetings and clinical governance meetings. The provider published reports internally and externally, and the service used the information to improve care and treatment and patients' outcomes.

Staff used technology to support patients effectively. They used electronic dashboards to monitor patients' health scores, in accordance with the provider's physical health strategy. Care records included full physical health care

checks, including a routine annual electrocardiogram and blood tests. They used the Liverpool University neuroleptic side effect rating scale to monitor the side effects of medication.

Staff participated in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review and approved service accreditation schemes. Accurate and up-to-date information about effectiveness was shared internally and externally and understood by staff. It was used to improve care and treatment and people's outcomes and this improvement was checked and monitored.

High performance was recognised by credible external bodies, such as the Royal College of Psychiatrists. The rehabilitation service had been an associate member of the 'accreditation for inpatient mental health service scheme' for their locked rehabilitation services since May 2018. Self-assessment benchmarking reports had been completed and the service became developmental members in May 2019.

The provider had completed an audit of the collaborative physical health assessments (Lester tool) in May 2018. This was repeated in January 2019 and the data undergoing analysis.

There were weekly reports on care plan compliance. Any areas of concern were monitored and addressed. Completion of physical health assessments was one of the quality performance indicators. In addition, 'documentation' quality walk rounds monitored patients' physical health needs and ensured key information was up-to-date and relevant.

The provider had completed a Mental Health Act audit for each patient. The audit tool covered basic patient data, care planning and assessments, section 17 leave documentation, treatment under section 58 and information to patients under section 130d and 132.

A spreadsheet was maintained for all detained patients with reference to section renewals, mental health tribunals and consent to treatment status. There was an admissions checklist completed for all patients. A 'documentation' quality walk round also monitored whether patients' capacity to consent to treatment had been assessed in a timely way with the correct documentation in place. Any issues arising from these audits were scrutinised and responded to appropriately through the service's clinical governance meetings.

The service had participated in the national audit of schizophrenia in September 2018, auditing prescribing practice, physical health monitoring and activity within psychological therapies.

There had also been an audit to establish the extent of high dose and combination antipsychotic prescribing. The reason for the audit was that high dose and combination antipsychotic treatment is associated with a higher risk of physical health problems. The audit therefore included consideration of the necessary physical health monitoring of patients on high dose antipsychotic therapy. In view of the limited evidence of benefit from using high dose or combined antipsychotics, the audit checked that effectiveness was monitored.

The provider had audited the service against the national guidelines for mental health services for patients with a learning disability and subsequently developed practice in this area of care. Some patients also had care and treatmentreviews alongside the care programme approach; thus, there was a clear link with learning disability and autism specialist services.

As part of their annual internal auditing mechanisms, the service were in the process of auditing observation and engagement practices and evaluating risk assessments on the electronic system.

The service had reviewed the risk assessment audit, and found issues relating to patients' privacy and dignity. There was an action plan to produce specific care plans addressing this.

Seclusion audits were carried out each time a patient came out of seclusion. The audits were reviewed and the findings fed back to the ward staff.

A meaningful week audit was completed every week ensure that each patient had a minimum of 25 hours of activities planned for the coming week. If there were any patients that did not have activities planned or fell below the 25 hour minimum expectation the ward managers were

notified. There was a recovery worker for every ward, who were not included in the 'safe staff' numbers. This meant there were always staff available to facilitate activities and escorted leave.

Each week, managers checked that clinical notes had been signed by practitioners and a report sent to department heads, who then ensured that any unconfirmed notes were signed, assuring good general data protection regulation practice.

There was an infection control audit in June 2018. This covered cleanliness, catering and a clinical perspective, involving the whole team. Current progress indicated green overall with a small number of amber actions relating to maintenance issues, which were in progress.

A ligature audit was completed in January 2019. The risk register was updated to reflect findings regarding wardrobe doors. Actions had been taken to mitigate the identified risk.

The provider participated in an annual safeguarding audit as a quality performance indicator. The audit related to performance in documentation, training and governance. All safeguarding concerns and CQC notifications completed were reviewed. They met monthly with the local safeguarding authority to review all safeguarding referrals (including those that did not meet the local authority threshold) to ensure any learning was shared.

The patient reported experience and outcome measures NHS England audit was completed in November 2018.

The provider had participated in a limited audit of reducing restrictive practice. This triggered an internal benchmarking exercise against national restraint reduction network standards. There were established themes and work streams and a project steering group to take forward the actions from this exercise. These were to eliminate prone restraint and to carry out a review of reducing restrictive practice.

The provider commissioned ex-patients to peer review patient and staff views of reducing restrictive practice projects and their effectiveness. The review was undertaken by facilitating on-site discussion forums, individual meetings and review of all reducing restrictive practice documentation and processes.

A book was provided on each ward for all patients and staff to document a suggestion or query regarding any restrictive practice. These were reviewed at weekly community meetings and monthly ward planning and development meetings, and escalated to service user council and hospital governance meetings.

Skilled staff to deliver care

Patients had access to the full range of specialists required to meet their needs. This included occupational therapists, clinical psychologists, social workers, pharmacists, speech and language therapists, a GP, podiatrists, physiotherapists, dentists and dieticians as well as medical and nursing staff.

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care and managers made sure that staff had the opportunity to develop the skills they needed. Managers proactively supported and encouraged staff to acquire new skills, use their transferable skills, and share best practice.

We reviewed six staff records. Staff were experienced and qualified. They had the right skills and knowledge to carry out their roles effectively and in line with best practice, to meet patients' needs. They had accessed a range of training. Managers supported staff through appraisals, supervision and opportunities to update and further develop their skills.

New staff had a comprehensive induction that incorporated the care certificate for non-registered clinical staff. The care certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It sets out national standards that underpin the required skills, knowledge and behaviours to ensure staff provide compassionate and high quality care and support.

Induction included the ethos of person centred care, values-based approaches, collaborative risk assessments and a conflict management course that included primary, secondary and tertiary preventative strategies.

The provider's values were linked to supervision and appraisal. Managers supported staff to deliver effective care and treatment through annual appraisal and regular supervision meetings, to discuss case management, to reflect on and learn from practice, for personal support and professional development, and appraisal of their work performance. They ensured that staff had access to regular team meetings.

All staff had had an appraisal in the 12 months before this inspection. Appraisal included setting objectives for personal development.

Staff received monthly supervision. There was a policy that provided guidance for staff. Supervision was established in the service culture. As well as formal records of supervision meetings, staff also kept an individual supervision 'passport' where they recorded all types of supervision. This included group supervision, reflective learning and informal discussions as well as regular meetings with their supervisor.

Management supervision included key performance indicators for staff, such as all assessments and care plans having been completed in a timely manner and one-to-one sessions with patients taking place. Records included discussion of appraisal objectives, national guidance, training needs and training undertaken, and patient engagement.

Staff also received monthly clinical supervision. This could be through individual or group supervision, or specialist peer supervision if that was appropriate. Staff were able to choose their supervisor. Clinical supervision ensured staff could develop the skills needed to ensure patients received high quality care, treatment and support. It provided guidance for individual development and an opportunity for staff to feel supported, motivated and confident.

Individual staff had a supervision contract with their supervisor that included agreed ground rules, and they kept their own confidential notes.

Most staff had received and were up to date with both clinical and management supervision:

Hawthorn - 89%

Oakwood - 82%

There was a strong focus on improvement and many opportunities for learning and sharing across the service. Staff were encouraged to take time out to consider their practice and make improvements; for example, monthly reflective practice meetings were available for all staff. They said the opportunity to discuss challenges they encountered in their practice was invaluable in considering how care and treatment could be improved. These meetings enabled staff to explore the dynamics of the ward, or focus on the care and treatment of one particular patient and discuss strategies and approaches for dealing with this as a team.

Medical staff were supported through the process of revalidation. One doctor required and had been revalidated in the 12 months prior to this inspection.

Staff and managers identified learning needs as part of the supervision and appraisal process. Managers ensured that staff received the necessary specialist training for their roles. They provided staff with opportunities to build on their skills and supported them to develop their knowledge and experience.

Managers encouraged staff to develop skills in specialist areas; for example, one nurse was being supported to become an advanced practitioner. Staff from other disciplines told us that they had been supported to gain further experience and qualifications, so that patient care was improved.

Some nurses had previously been health care support staff. The provider supported them through training to become registered nurses.

In 2018, the provider had launched a career pathways project and all staff were enrolled onto a pathway that set out their potential career progression.

Managers dealt with poor staff performance promptly and effectively. There was a clear and appropriate approach to supporting and managing staff when their performance was poor or variable. Staff and managers discussed performance in supervision. Staff were encouraged to reflect on their practice and performance. This was evident in the records we reviewed. Managers explained the process they followed and told us they were very well supported in addressing poor performance.

Multi-disciplinary and inter-agency team work

Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services.

When patients received care from a range of different staff, teams or services, it was co-ordinated. All relevant staff, teams and services were involved in assessing, planning and delivering patients' care and treatment. Staff worked collaboratively to understand and meet the range and

complexity of patient's needs. The multi-disciplinary team (MDT) worked effectively to co-ordinate person-centred patient care and support patients' recovery in line with best practice guidance. The MDT held weekly meetings, with each patient's involvement. They planned care and treatment in a holistic, patient-focused way and established the patient's views to ensure they were involved in developing their care plan. Open invitations were offered to care co-ordinators and carers, and there were good relationships with community teams.

There were handover meetings at the change of every shift. Staff discussed issues relating to patient safety, risks and observation levels.

Every morning, senior managers and all ward managers met to review issues such as referrals, admissions, discharges and transfers, reported incidents, observation levels, risks, safeguarding and complaints. We attended one of these meetings and found it to be well structured, informative and productive.

Staff held regular and effective multi-disciplinary team meetings, where they shared information about patients. Care co-ordinators were invited to the meetings and could attend via online conferencing facilities.

There were established, positive working relationships with referring clinical teams and care co-ordinators, and other service providers such as local authority social services, GPs, chiropody, opticians, podiatry and physiotherapy, and with a range of community groups where patients could undertake voluntary and vocational work placements. Some patients were involved in charity work such as supporting veterans in the community and conservation work.

Patients' discharge, transition and referral plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes.

Staff took a holistic approach, which began at the earliest possible stage. Staff from different disciplines, teams and services worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. Patients were discharged at an appropriate time and when all necessary care arrangements were in place.

Where discharges, transfers and transitions occurred unexpectedly, there were processes that ensured patients were not left at risk, including communicating their specific, individual needs.

Adherence to the MHA and the MHA Code of Practice

Training in the Mental Health Act (MHA) was mandatory, and 88% of staff had had training.

Managers supported staff to understand and meet the standards in the Mental Health Act Code of Practice. They understood their roles and responsibilities, and managers made sure that staff could explain patients' rights to them. They did this every month. They explained in ways that patients could understand and recorded that they had done it. They repeated the information when necessary. Patients understood their rights under the Act and they were empowered to exercise them. Some patients had exercised their right to appeal to the mental health tribunal (MHT) and/or the hospital managers. When necessary, the service had made referrals to the MHT. Decisions were recorded and patients were informed about decisions.

Staff worked effectively with others to promote the best outcomes for people subject to the MHA, with a focus on recovery.

Where patients were subject to the Mental Health Act, their rights were protected and staff complied with the associated Code of Practice. Adherence to the MHA and Code of Practice was good.

All treatment was given under appropriate legal authority and the relevant certificates were in place, along with review of treatment documentation for patients assessed as not being capable of understanding the nature, purpose and likely effects of the treatment. The responsible clinician had noted the patients' capacity to consent to treatment at the most recent authorisation. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff had good access to administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice. Staff knew who the Mental Health Act administrators were.

There were relevant policies and procedures that reflected the most recent guidance. Staff had easy access to the policies and procedures and to the Code of Practice.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

Patients had easy access to information about independent mental health advocacy. There was an independent mental health advocate who provided support to patients on request.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted. All patients had section 17 leave, either in groups or individual.

Staff stored copies of patients' detention papers and associated records, such as section 17 leave forms, correctly. Staff had followed the procedures for renewing detention and the criteria for renewal had been met. The records were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely.

Care plans referred to identified section 117 aftercare services for patients who had been subject to section 3 or part 3 powers authorising admission to hospital.

Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly, and there was evidence of learning from those audits. An audit had been completed for each patient in September 2018.

Good practice in applying the MCA

Training in the Mental Capacity Act (MCA) was mandatory, and 95% of staff had had training.

Staff understood and complied with the requirements of the MCA and the five statutory principles.

There was a policy on the Mental Capacity Act, including the Deprivation of Liberty Safeguards. Staff had easy access to the policy and they understood it. They knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards. The social work team provided guidance.

Consent to care and treatment was obtained in line with legislation and guidance. Staff assumed that patients had capacity and they supported patients to make decisions about their care for themselves. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

Staff understood that capacity fluctuated and that patients may have capacity to consent to some things but not others. They gave patients every possible assistance to make a specific decision for themselves before they considered that the patient might lack the mental capacity to make it.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Practices around consent and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.

Use of restraint was understood and monitored. Less restrictive options were used wherever possible.

Deprivation of liberty was recognised and only occurred when it was in a patient's best interests, was a proportionate response to the risk and seriousness of harm to the patient, and there was no less restrictive option to ensure the patient received the necessary care and treatment.

There were no patients subject to the Deprivation of Liberty Safeguards and there were no pending applications.

The service monitored adherence to the Mental Capacity Act. They audited the application of the Act and took action on any learning that resulted from it.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. They treated patients with compassion and respect. They respected patients' privacy and dignity, and supported their individual needs.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

Relationships between patients, those close to them and staff were caring, respectful and supportive. These relationships were valued by staff and promoted by leaders.

Care plans were holistic, personalised and recovery-oriented and patients' involvement was clear. Their specific preferences and needs, including their emotional and social needs, were reflected in how staff delivered care.

Patients were treated with dignity by everyone involved in their care, treatment and support. Consideration of patients' privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated. Patients' emotional, social and physical needs were considered equally. Staff responded compassionately when patients needed help. They anticipated patients' needs and supported them to meet their basic personal needs. They supported patients and those close to them to manage their emotional responses to their care and treatment.

Staff supported and enabled patients to manage their own health and care when they could and to maintain their independence as much as possible. They directed patients to other services when appropriate and supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them. Feedback from patients, those close to them and stakeholders was positive about the way staff treated patients. Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Patients felt supported and said staff cared about them.

They valued their relationships with the staff team. Staff understood patients' individual needs, including their personal, cultural, social and religious needs and took them into account. They recognised and respected the totality of patients' needs and ensured they could meet them. They supported patients to maintain and develop their relationships with those close to them, their social networks and the community.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Patients, those close to them and staff all understood the expectations of the service around privacy and dignity. Staff developed trusting relationships with patients. They recognised the importance of patients' privacy and dignity, and they always respected it. They challenged behaviour and practices that did not meet expectations.

Staff always respected patients' confidentiality. They met legal requirements about data protection. When patients' care and support was provided by a mix of different providers, the service minimised risks to privacy and confidentiality.

Involvement in care

There was genuine commitment to patient involvement. At the beginning of the inspection, patients, staff and the hospital director gave a presentation of their achievements and plans. Empowering and involving patients was clearly embedded in the hospital culture.

Staff supported patients to have a voice and to realise their potential. They communicated with patients and provided information in a way that they could understand. Patients understood their condition and their care, treatment and advice. Patients and staff worked together to plan care and there was shared decision-making about care and treatment. Patients' individual preferences and needs were always reflected in how care was delivered.

Patients and those close to them were active partners in their care. Patients, carers and family members were involved and encouraged to be partners in making decisions about care, and receive any support they needed. Staff spent time talking to patients and those close to them. Staff were fully committed to working in partnership with patients and making this a reality for each patient. Patients told us they understood their care and treatment. Staff supported patients to take as much responsibility for developing their care plans as they could. They were involved in planning and making decisions, including about discharge and about how they wished to be treated if a crisis occurred. Care plans were written from the patient's viewpoint. Their involvement in developing their own care plans was documented. They added their own notes to their care records. Patients were all offered a copy of their own care plan. With the patient's agreement, their family, friends and advocates were also involved. Staff facilitated carers' involvement.

One patient had created a large 'my journey' map, which was displayed in the corridor. It showed his pathway from his admission to preparation for discharge, starting with 'how I first felt' when he was first admitted, then 'when I settled in' 'what I can do now' and 'what I am working towards'. This was a meaningful therapeutic tool that could be used to help other patients understand the recovery pathway.

Patients had been involved in the recruitment and interview process for all staff. They were also involved in the induction process and provided an overview to new staff.

Staff valued feedback as an essential mechanism to ensure they understood patients' expectations, experiences and needs, and could learn and implement any changes from their feedback. There were systems to ensure patients could give feedback and their views were considered.

Patients' experiences were captured via various mechanisms including patient satisfaction surveys, using online and hard copies, and compliments books. Some ex-patients visited to talk to current patients about the treatment programme.

Patients were represented on several groups, such as the physical health group, recovery college group and ward planning and development teams.

The documentation and service user quality walk rounds monitored patient and carer involvement in the development of care planning. The results were used to improve on quality and standards.

There were weekly community meetings on the wards, chaired by nominated patients. Patients had opportunity to discuss wider hospital issues and contribute to the day-to-day running of the ward. Staff actively encouraged them to take part in community meetings. Minutes and actions from the meetings were displayed on the wards. The minutes documented discussion about issues patients raised and there were action plans to address them.

One patient was particularly proud of his achievements, and the support staff provided. It was clear that he felt completely respected by staff and involved in the running of the ward in as much as was possible.

There was a monthly service user council meeting that discussed matters raised by patients. Both wards had patient representatives on the service user council. All patient representatives were encouraged to attend the meetings. The hospital director chaired the service user council meetings and all heads of departments attended.

A representative of the service user council also attended the clinical governance meetings. They raised additional issues as needed, and provided updates on issues that required attention from the wards. We saw meeting minutes that confirmed the respect given to patients' views and opinions.

A service user experience of care survey was carried out in 2018. The data collected across both wards was mostly positive, with some very positive comments from service users. All service users who completed the survey agreed they felt safe on the wards and that staff were supportive and treated them with respect. Comments included, 'staff are the best' and 'staff are very helpful and supportive'.

Patient reported experience and outcome measures NHS England audit surveys were carried out every quarter. The results were discussed at clinical governance meetings and associated actions from the reports allocated to the appropriate heads of departments.

Recent local survey comments had reflected a need to review menus and food provision. To address this, the head chef established focus groups to take feedback and incorporate comments into menu planning.

Direct feedback from patients had suggested that activities were inconsistent in their delivery and that in some instances, where there were vacancies in the occupational therapy team, activities were largely self-led. As a direct result of these comments, agency occupational therapy staff were engaged.

There was a survey of a small sample of three out of seven patients discharged between October and December 2018. The results were mainly positive. An action plan was drawn up and completed to ensure an increased response rate going forward, so that more meaningful data could be gathered.

There was an annual family and friends survey. In 2018, the results were mainly positive, with carers feeling respected, understood and communicated with. The results were analysed and an action plan produced to improve practice. The action plan was further developed in a family and friends event held in March 2019.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

There were quarterly carers' meetings, which had a high attendance rate. There were incentives for carers to attend the group, such as being able to have lunch with their loved one, or scheduling a visit either before or after the meeting. Carers were involved with a range of issues, including training. This supported carers and patients to form wide support networks.

Staff ensured that patients could access advocacy. They recognised that patients needed to have access to, and links with, their advocacy and support networks in the community and they supported patients with this. Staff ensured that patients' communication needs were understood, followed best practice and learned from it. Patients had direct access to advocacy services and there was information displayed on the wards.

Staff gave families and carers appropriate information, and provided them with support when needed. They gave carers advice on how to access a statutory carers' assessment, provided by an appropriate agency. They provided each carer with a carers' information pack.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Outstanding ☆

Access and discharge

The service specialised in long term, complex patients, some of whom had specific risk histories or life limiting illnesses. Access to care was managed to take account of patients' needs. Waiting times from referral to treatment, and arrangements to admit, treat and discharge patients were in line with good practice.

Staff used the care programme approach as a framework and timeline for planning and co-ordinating support and treatment.

Patients were admitted from a range of different settings including secure units, prisons and other inpatient units. All admissions were planned.

There were clear care pathways. Patients were assessed before they were admitted so that they received the most appropriate care and treatment.

Between 1 July and 31 December 2018, average bed occupancy was:

- Hawthorn - 99%
- Oakwood - 95%

For current patients, at 31 December 2018, average length of stay in days was:

- Hawthorn - 589
- Oakwood - 1660

Of patients discharged during the 12 months up to 31 December 2018, the average length of stay in days was:

- Hawthorn - 613
- Oakwood - 1773

According to the 2018 CQC review of rehabilitation services, the length of stay is one to two years for high dependency services, and five to ten years for services specialising in long term and complex patients, some of whom have specific risk histories or life limiting illnesses.

The average length of stay for each ward was reflective of patients' needs.

There was always a bed available when patients returned from leave.

Patients were not moved between wards unless it was justified on clinical grounds and was in their interests.

When patients were moved or discharged, this happened at an appropriate time of day. Staff supported patients during referrals and transfers between services; for example, if they required treatment in an acute hospital.

Staff took a holistic, person-centred approach to support patients in their recovery. They ensured patients did not stay in hospital longer than necessary.

Staff planned for patients' discharge, including good liaison with care co-ordinators, to ensure patients had the support they needed when they were discharged. Discharge was never delayed for other than clinical reasons.

Between 1 July and 31 December 2018 there were no delayed discharges and no readmissions within 90 days.

Staff considered discharge arrangements from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. Care records contained plans for discharge, transfer or transition to other services, including potential future placements. Discharge plans were developed in care planning. Patients were engaged in community based activity as much as possible, such as education and employment opportunities, and staff supported them to develop social networks. Leave was used to monitor patients' progress towards discharge. Discharge plans were reviewed and updated at each multi-disciplinary team meeting. Patients knew approximately when they would be discharged and where to.

Patients were admitted from various parts of the UK due to placements that would meet their needs not always being available in their home area.

Staff worked closely with care co-ordinators, commissioners and other providers to plan and facilitate discharges and ensure patients were fully supported. Discharges or transfers were discussed and planned by the multi-disciplinary team. The service followed national standards for transfer.

There was a policy for unplanned discharge, along with identified actions in the care plans.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings supported patients' treatment, privacy and dignity.

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. All bedrooms were en suite. Patients always had access to their rooms. They had personalised their bedrooms, and all had secure lockable storage for their possessions. Banned items, such as cigarettes and lighters, were kept securely by staff.

The bedrooms had vistamatic windows covered by a blind that patients could operate from inside their rooms.

Patients had access to the gardens on all wards. The gardens were secure with a high fence. There was seating and raised flower and vegetable beds that patients tended. The hospital grounds were spacious with gardens, a woodland walk and seating areas.

Staff and patients had access to a full range of rooms and equipment to support care and treatment. Each ward had a range of therapy rooms, a clinic room, a visiting room, a large lounge and two kitchens. One kitchen was for occupational therapy assessments or for patients to cook on their own. On all wards, this kitchen was kept locked.

On Hawthorn, the ward manager told us that all the drawers and cupboards in this kitchen were left unlocked. They were only locked if the patient using the kitchen presented a risk, which was assessed individually. If a patient was using the kitchen, they could open the door to leave but the kitchen remained locked from the outside so other patients could not access it whilst it was in use.

On Oakwood, the kitchen where patients cooked food was kept locked but the drawers were not. This had been agreed in a patient community meeting as food had been going missing. Patients had become upset and angry so it was agreed the kitchen should be locked as a solution.

Patients could make drinks or snacks whenever they wanted to in the main ward kitchen, which was kept open. They had individual lockers to store non-perishable food items.

Staff supported patients who were self-catering to budget, shop for and cook their own food.

There were quiet areas for privacy and where patients could be independent of staff.

There was a pay phone on each ward where patients could make a private phone call. Access to mobile phones, including smartphones, was individually risk assessed.

Patients had access to a computer and could access the internet although they had to ask staff for a password.

Most patients thought the quality of food was good. Staff sought regular feedback on the quality of food.

There was a wide range of activities available seven days a week, both on and off the wards. Each ward was trialling having a dedicated activity nurse, who was not included in the safe staffing numbers. The activity programme provided opportunities for personal growth and development of social and inter-personal skills. Therapeutic activities included woodwork, art, music

groups, swimming, cycling, walking, a gym, smoking cessation and mindfulness groups. There was also access to a horticultural area, IT suite, an education centre, therapy rooms and a sports hall.

All patients had a timetable to identify their individual activity and support needs. There was also a timetable of open groups that anyone could join in. The activities were varied and took place all through the week, including weekends. Some continued into the evening. Activities were personalised to accommodate patients' preferences, provide support and promote community and social inclusion, with the focus on recovery and safe rehabilitation into the community.

The sports hall was also used for social events such as cinema nights, and patients could access the on-site gym after 5pm as well as during the day. Activity focused on promoting recovery and developing skills to maintain independence.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

They supported patients to maintain contact with their families and carers. They facilitated visits home and with the people close to them. Patients could use online conferencing facilities to keep in touch with the people close to them. Patients had also facilitated a family and carers' open day.

Staff encouraged patients to use community facilities wherever possible. This promoted appropriate behaviour and life in the wider community. Leave authorised under section 17 Mental Health Act 1983 was well structured, so that patients could access a range of activities.

The service had several community partners, such as local colleges for the recovery college, a local football club, sports initiatives, voluntary organisations and user forums. The service user council was represented on the committees of these groups.

There were innovative approaches to providing integrated person-centred pathways of care that involved other organisations and the local community. This was fundamental to planning and ensuring that the service met patients' needs. Staff supported patients to take part in mainstream activities and to exercise their right to be a citizen as independently as they were able to.

Patients had access to a range of 'real work' opportunities, both on-site and in the community.

There was an excellent range of joint initiatives that the service had developed with external organisations.

Patients applied and attended interviews for these opportunities and received training to support them. On-site opportunities included being involved in staff recruitment, induction and training. Other opportunities included working in the on-site café, painting and decorating, catering, horticultural work and looking after animals.

Patients also participated in community groups and activities; for example, neighbourhood groups, learning, and volunteer opportunities, such as conservation work, working at an animal sanctuary, working at a food bank and food kitchen, and supporting veterans. Patients also took part in training sessions with a local football club. One patient had gained his FA level 1 coaching badge. Another patient had presented their story to 80-90 people at a boot camp. This reinforced the focus on access to education and employment opportunities. Patients and staff viewed these opportunities as positive, recovery focused work experience.

Patients had access to recovery college courses, developed in partnership with local colleges. There was a team of tutors and education facilitators who supported patients to access a range of educational opportunities. The recovery college offered various courses to support patients to build skills in a range of areas, including self-management, communication, team working, emotional intelligence and problem solving. Some patients who had been discharged came back to share their experiences. This offered patients who were still in hospital opportunities to learn through the experiences of others.

Course subjects included internet safety, interviewing skills, food hygiene and catering, and chairing meetings. The provider held a graduation ceremony and patients received a certificate on completing a course. Some had completed vocational qualifications such as horticulture and catering.

Meeting the needs of all patients

The service valued diversity. Care and treatment was accessible to all who needed it and took account of

patients' individual needs. Staff made every effort to ensure that services, buildings and facilities were accessible to all whatever their disability, and that all patients received equitable treatment.

There was a proactive approach to understanding the needs and preferences of different groups and to delivering care in a way that met those needs, was accessible and promoted equality. This included patients with protected characteristics under the Equality Act, patients approaching the end of their life, and patients in vulnerable circumstances or who had complex needs. Staff made reasonable adjustments and took action to remove barriers when patients found it hard to use or access services. For example, when patients were fasting for religious reasons, they adjusted times when food was available to meet the patients' needs.

All staff received training on the Equality Act 2010. Some staff had completed 'train the trainer' training for lesbian, gay, bisexual, and transgender (LGBT) issues. There was an LGBT champion.

Staff assessed patient satisfaction with equality and diversity through patient discussions at community meetings, ward rounds, care programme approach meetings, quality walk rounds and the complaints procedure.

Information leaflets were available in a range of languages and formats. Interpreters were available for patients who needed them.

All the wards had an accessible shower and bedrooms identified for patients with mobility needs on the ground floor. The accessible bedroom on Hawthorn contained an ordinary bed but the manager told us this could be removed and changed to a hospital bed if needed.

Staff helped patients with communication, advocacy and cultural support. There was information about the independent mental health advocacy service and how to contact the advocate.

There was a project about communication disorders designed to ensure an enabling environment. Staff attended learning disability and autism service line meetings and local autistic spectrum disorder access assessment team meetings, to ensure their practice was up to date and in line with best practice.

Staff supported patients' spiritual and religious needs. There was a dedicated multi-faith room for prayer in the grounds, with equipment related to different religions. Staff told us that they would facilitate all patients' religious and spiritual needs, preferably within the local community.

Care was tailored to meet the needs of individual patients and delivered in ways that ensured flexibility, choice and continuity of care. Patients' individual needs and preferences were central to the delivery of personalised services. Patients were involved in the design and delivery of services via the service user council.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs.

Care and treatment were co-ordinated with other services and other providers. This included liaising with families and carers and ensuring that all services were informed of any diverse needs that needed to be addressed.

The importance of flexibility, informed choice and continuity of care was reflected in the service. Patients' needs and preferences were considered and acted on to ensure that the service was delivered appropriately.

Activities included over-50s walking football and pet therapy. Patients had made willow sculptures in the woodland walk and developed a new garden layout. Some patients had been recruited as gardeners for real work opportunities. There was a patient choir and band that performed at external venues.

There was a range of information about treatment, safeguarding, patients' rights and complaints information. Information on mental health problems and medication was available and there were advice sheets about medication on the wards. Information was available in different accessible formats, such as easy read or braille, or in different languages, if required. Interpreters and signers were available if needed. Hawthorn used laminated placemats in the dining room that had a different theme every month, such as information about diabetes, in easy read format with colourful pictures and key facts. These had been well received by patients, who had helped to decide themes and develop them.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Staff used

portion control to maintain a healthy diet. There were meal choices for vegan and halal diets and for patients who had allergies or medical conditions, such as diabetes. The menus incorporated a 'traffic light' system so that patients had nutritional information about food choices. The chef met with patients to discuss menus and requirements, and patients had nutritional information about food choices.

Listening to and learning from concerns and complaints

During the 12 months to 31 December 2018, the service received seven complaints:

- Oakwood - 2
- Hawthorn - 5

One complaint was upheld. None of the complaints were referred to the parliamentary and health services ombudsman.

Each ward kept a log of complaints. Informal complaints were resolved at ward level if possible. All complaints had been dealt with promptly.

During the same time period, 64 compliments were received.

Patients knew how to complain or raise concerns. There were boxes in the patient areas for comments and suggestions. There was information about how to complain displayed on the wards. The complaints process was always followed whether patients complained formally or informally.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The service used learning from complaints and concerns as an opportunity for improvement.

All complaints were discussed at daily handover meetings and the senior managers' morning meeting. Following the investigation of a complaint, staff received feedback and any recommendations for improvements. Complaints outcomes were communicated to staff via team briefings and individual supervision. Any themes and lessons learnt were communicated throughout the organisation and addressed appropriately. This included lessons from complaints at other sites.

Patients were involved in reviewing complaints and how they were managed via the service user council. The service made improvements as a result of learning from reviews, and that learning was shared with other services.

Patients knew how to give feedback about their experiences, including how to raise any concerns or issues, and could do so in a range of accessible ways.

Patients, their family, friends and other carers felt confident that if they complained, they would be taken seriously and treated compassionately. They felt that their complaint or concern would be explored thoroughly and responded to in good time because the service dealt with complaints in an open and transparent way, with no negative repercussions.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Outstanding ☆

Leadership

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

Managers had the right skills and abilities to run a service providing high-quality sustainable care.

There was compassionate, inclusive and effective leadership at all levels. This was sustained through a leadership strategy and development programme, effective selection, deployment and support processes, and succession planning.

Leaders demonstrated the high levels of experience, capacity and capability and integrity needed to deliver excellent and sustainable care. Leaders at every level were visible and approachable for patients and staff.

There was an established system of leadership development and succession planning, which aimed to ensure that the leadership represented the diversity of the workforce.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

There were comprehensive and successful leadership strategies to ensure and sustain delivery and to develop the desired culture.

Leaders had a deep understanding of issues, challenges and priorities for quality and sustainability in their service, and the wider community. They understood what the risks to performance were and they acted to address them.

Vision and strategy

The provider had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a clear statement of vision and values, driven by quality and sustainability. It was translated into a robust and realistic strategy and well-defined objectives that were achievable and relevant.

The strategy was developed through a structured planning process in collaboration with patients, staff and external partners. It was aligned to local plans in the wider health and social care economy and services were planned to meet patients' needs.

The values were:

1. We put safety first

2. We put the people we care for at the centre of everything we do

3. We take pride in what we do and celebrate success

4. We value our people

5. Your voice matters

The purpose was to make a real and lasting difference for everyone the service supported. There was a common focus on good care.

Leaders actively promoted the values and behaviours to ensure staff understood them. A copy of the values and behaviours was sent to every employee in the company with their wage slips. Posters were displayed across site and there were 'credit cards' for staff detailing the values and expected behaviours. The provider's values and expected behaviours had also been integrated into the care certificate workbooks, and were actively promoted on the intranet. During the recruitment process, the corporate provider behaviours informed the selection process to ensure that candidates understood the required standards.

In addition, there were quality assurance processes that ensured the care provided was good. Where improvements were required, staff took appropriate action in a timely manner, in line with the values and behaviours. This included quality walk rounds, which formed part of the clinical governance policy. The walk rounds were conducted by members of the management team, regional quality improvement leads, and staff and service users. The outcomes of the walk rounds were collated and actions followed up and disseminated. The values were also integrated into everyday business via team meetings, lessons learned and handover meetings.

The vision and values were embedded in the service and in individual practice. Staff knew and supported the vision, values and strategic goals and understood how their role helped in achieving them. At each supervision session, staff were expected to demonstrate how the vision and values were integrated into their practice.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were implemented consistently and had a positive impact on quality and sustainability of services.

There were measurable outcomes that supported the strategy. Staff understood the challenges to achieving the strategy, including relevant local health economy factors, and there was an action plan and they had opportunities to contribute to discussions about the strategy.

Culture

There was a highly positive, transparent and person-centred culture across the location. The leadership was inspiring and proactive in guiding others to achieve successful outcomes for patients, and this clear commitment was replicated throughout the hospital site.

There was a huge commitment to recovery at all levels. Staff were highly motivated for patients to be discharged. There was a great emphasis on supporting patients to develop and build the skills they needed to live independently in the community.

Staff encouraged patients to become part of the wider community by participating in opportunities away from the hospital site.

Staff were committed to encouraging patient involvement. Patients were involved in the service at all levels, including governance.

Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff felt respected, supported and valued. They were proud of the organisation as a place to work and spoke highly of the culture.

There were high levels of satisfaction among staff, including those with protected characteristics under the Equality Act. There was a strong organisational commitment towards ensuring equality and inclusion across the workforce. Leaders actively promoted equality and diversity. The causes of any workforce inequality were identified and action taken.

Staff felt able to raise concerns without fear of retribution. They were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this. Candour, openness, honesty, transparency and challenges to poor practice were typical. Leaders actively promoted staff empowerment to drive improvement. Raising concerns was encouraged and valued. Staff actively raised concerns and when they did they were supported. Managers investigated concerns sensitively and confidentially, and they acted on lessons learned and shared them. Staff understood what a notifiable safety incident was and what they were expected to do. When something went wrong, patients received a sincere and timely apology and staff told them about any actions being taken to prevent the same happening again.

There was strong collaboration, team-working and support and a common focus on improving the quality and sustainability of care and people's experiences. Leaders encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. There were processes and initiatives to support staff and promote their positive wellbeing. Staff success was recognised through staff awards. The recovery team had won the provider's 'Pride' award for their work.

There was a culture of collective responsibility between teams and services. There were positive relationships between staff and teams, where conflicts were resolved quickly and constructively and responsibility shared. There were processes for providing all staff with the development they needed, including high-quality appraisal and career development conversations.

Leaders promoted shared values, prioritised high-quality, sustainable and compassionate care, and promoted equality and diversity. They encouraged pride and positivity in the organisation and focused attention on the needs and experiences of patients. Behaviour and performance inconsistent with the vision and values was identified and dealt with swiftly and effectively, regardless of seniority.

Governance

There was a systematic approach to continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish, and working with other organisations to improve care outcomes.

There were clear governance systems that ensured oversight of the service. There was a 'ward to board' model of governance. Staff were encouraged and supported to be involved in the governance process. Patients were involved in governance at all levels. Governance arrangements were reviewed proactively and reflected best practice.

All levels of governance functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

There was a clear framework of what was to be discussed at ward, team or directorate level to ensure that essential information, such as safeguarding information, and learning from incidents and complaints, was shared and discussed. All policies were reviewed regularly and updated. The service user council was represented at governance meetings. Meeting minutes were structured and informative, clearly addressing quality issues.

CQC's Mental Health Act reviewer reports were reviewed. Senior managers were aware that any required action had been taken to address identified issues. Statistical information on the operation of the Act was monitored. Statistical information on patterns of admission and length

of stay was considered and compared with national data. Mental Health Act documentation and compliance was overseen and reported on by the Mental Health Act administrator.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts.

Staff participated in local clinical audits, such as audits of care records, environmental audits and audits of infection control systems. The audits were monitored via electronic quality dashboards. They were sufficient to provide assurance and staff acted on the results when needed.

Quality and safety were monitored via electronic dashboards. Quality performance indicators were monitored and reported on every month.

Annual quality improvement objectives were set and clinical audits conducted. The information was collated and an audit report disseminated. Objectives included undertaking a literature review to look at patient motivation, and the introduction of a protocol to support behavioural activation, and positive behavioural interventions using the clinical intervention of positive thinking training.

Management of risk, issues and performance

There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. Staff maintained and had access to the risk register at ward level. They could escalate concerns if they needed to. There was an overarching strategic risk register at board level.

There were plans for managing identified emergencies such as the premises becoming not fit for purpose, adverse weather or an outbreak of illness. Other identified risks included staff retention, breakdown of key customer relationships and information technology failure. There were controls in place to mitigate the likelihood and impact of all identified risks.

There were processes to manage current and future performance. There was a demonstrated commitment to best practice performance and risk management systems and processes.

The provider reviewed how the service functioned and ensured that staff at all levels had the skills and knowledge to use systems and processes effectively. Problems were identified and addressed quickly and openly. There was a clear 'no blame' culture, whereby no individual was deemed responsible. When something went wrong, the service looked at why and how the system had gone wrong, what steps were needed to rectify that, and took those steps.

Performance issues were escalated appropriately through clear structures and processes. Clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns.

Where cost improvements were taking place, they did not compromise patient care. Financial pressures were managed so that they did not compromise the quality of care. Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care was understood.

Information management

The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The provider invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was consistently accurate, valid, reliable, timely and relevant.

There was an holistic understanding of performance, which included quality, operational and financial information. Quality and sustainability both received good coverage in relevant meetings at all levels.

There was commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The data they received supported them to adjust and improve performance as necessary. Performance information was used to hold management and staff to account.

Staff had access to the equipment and information technology they needed. The information technology infrastructure worked well. Integrated reporting supported

effective decision making and helped to improve the quality of care. The systems to manage and share the information needed to deliver effective care treatment and support were co-ordinated and supported integrated care for patients. Information governance systems protected confidentiality of patient records.

Data or notifications were consistently submitted to external organisations as required. There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems were used effectively to monitor and improve the quality of care.

Engagement

Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. They actively shaped the culture through consistently high levels of constructive and effective engagement with staff, patients and carers, including all equality groups, and external stakeholders such as commissioners. They welcomed rigorous and constructive challenge and saw it as a vital way of holding the service to account. They were committed to promoting engagement to increase the chances of achieving better outcomes, both business and patient focussed.

Services were developed with the full involvement of patients, staff and external partners, as equal partners. There was a demonstrated commitment to acting on feedback. The service proactively engaged and involved all patients and staff, including those in different equality groups, so that a full and diverse range of views and concerns was encouraged, heard and acted on to shape the service and culture.

The provider was transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the patient group, and to design improvements to meet them.

Patients and carers were involved in decision-making about changes. They had opportunities to give feedback on the service in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

There were annual staff surveys that showed high levels of satisfaction, with action plans for improvements based on the findings. For example, 18% of staff overall did not respond to the survey and there was an action plan to capture this missed population as part of the 2019 employee engagement strategy. Changes made because of the survey findings included increased flexible working applications being supported, access to line managers being facilitated to agree career pathways and complete annual appraisal, introduction of a night allowance, and increased profile of the 'working well' group and its staff wellbeing activities.

The employee engagement strategy for 2019 built on the issues raised by staff via a variety of forums, including the established open door policy across site, 'your say' forum, staff meetings and staff surveys.

All staff were enrolled on a career pathway. Some health care support staff had been supported through training to become registered nurses. All staff had opportunities to be seconded to other services.

There was an established 'working well' initiative to promote staff retention and reduce sickness rates. Staff had presented this at a Royal College of Psychiatristsevent and the initiative was a Nursing Times awards finalist. Funds were raised via 'dress down' days and 'bacon butty' days, then used to hold a staff event with prizes, massage and relaxation sessions, and breakfasts for staff being delivered to wards. Other support for staff included increased flexible working arrangements, which could be for various reasons such as to attend college or to care for children or other relatives.

Staff were proud of the organisation and the positive culture. They felt respected, valued and supported, and they were committed to providing quality care.

Learning, continuous improvement and innovation

There was a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

There was a fully embedded and systematic approach to improvement, which made consistent use of improvement methodology. Improvement was viewed as the way to deal with performance and for the organisation to learn.

Long stay or rehabilitation mental health wards for working age adults

Outstanding ☆

Improvement methods and skills were used across the organisation. There were organisational systems to support improvement and innovation work, including staff objectives and rewards, and staff were empowered to share improvement work, and to lead and deliver change. Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work locally and nationally.

The service made effective use of internal and external reviews, and learning was shared effectively and used to make improvements. Staff were encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. They were supported to consider opportunities for improvements and innovation and this led to changes. For example, they had implemented the use of new assessment tools and outcomes measures, and had reviewed the implementation of the 'safe wards' model of care supported by the 'reinforce appropriate, implode disruptive' positive psychology approach.

Staff participated in national audits relevant to the service and learned from them.

The service participated in relevant accreditation schemes and learned from them. The rehabilitation service was a developmental member of the Royal College of Psychiatrists accreditation for inpatient mental health service scheme for their locked rehabilitation services.

Outstanding practice and areas for improvement

Outstanding practice

There was a highly positive, transparent and person-centred culture across the location.

The leadership was inspiring and proactive in guiding others to achieve successful outcomes for patients, and this clear commitment was replicated throughout the hospital site.

There was a huge commitment to recovery at all levels. Staff were highly motivated for patients to be discharged. There was a great emphasis on supporting patients to develop and build the skills they needed to live independently in the community. Interventions were evidence-based and recovery focused. They included developing a 'skill of the week' and a responsible living group. Patients were involved in developing their own treatment programmes.

Activity focused on promoting recovery and developing skills to maintain independence, to reduce the time patients needed to stay in hospital. Opportunities to develop skills on the hospital site included 'real work' experiences such as painting and decorating, gardening, looking after livestock and catering. Staff encouraged patients to become part of the wider community by participating in opportunities such as education, employment and leisure activities away from the hospital site. Some patients who had been discharged came back to the hospital to share their experiences. This offered patients opportunities to learn through the experiences of others.

Staff were committed to encouraging patient involvement. Patients were involved in the service at all levels, including governance. The service user council was involved in reviewing incidents and complaints, attended clinical governance meetings, participated in the design and delivery of services and was represented on the committees of community partnerships.

Patients were protected by strong comprehensive safety systems, and a focus on openness, transparency and learning if things went wrong. The whole team was engaged in reviewing and improving safety and safeguarding systems.

Care, treatment and support achieved excellent outcomes for patients, promoted a good quality of life and was based on the best available evidence.

Staff involved patients and treated them with compassion, kindness, dignity and respect. Staff genuinely respected patients and valued them as individuals. Patients were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

The service was personalised to meet the needs of individual patients and delivered in a way that ensured flexibility, choice and continuity of care.

The leadership, management and governance of the organisation assured delivery of high-quality and person-centred care, supported learning and innovation, and promoted an open and fair culture.

Support for staff included developing their skills through high quality training, appraisal and supervision, and established initiatives to promote staff wellbeing and retention. Success was recognised through staff awards. There was a clear 'no blame' culture, whereby no individual was deemed responsible when something went wrong. When this happened, the provider looked at why and how the system had gone wrong, what steps were needed to rectify that, and took those steps.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all staff know where environmental risk assessments are stored.
- The provider should monitor implementation of the amended medicines management system and procedures.