

Good 

South Staffordshire and Shropshire Healthcare NHS  
Foundation Trust

# Forensic inpatient/secure wards

## Quality Report

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Date of inspection visit: March 2016

Date of publication: 12/07/2016

### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RRE10	St Georges Hospital	Ashley Ward	ST16 3AG
RRE10	St Georges Hospital	Ellesmere House	ST16 3AG
RRE10	St Georges Hospital	Norton House	ST16 3AG
RRE10	St Georges Hospital	Radford ward	ST16 3AG
RREX9	The Redwoods Centre	Willow ward	SY3 8DS
RREX9	The Redwoods Centre	Yew ward	SY3 8DS

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

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

# Summary of findings

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

- The service provided good quality, safe environments that promote recovery.
  - We saw a proactive approach to de-escalation which had resulted in low levels of incidents and seclusion use.
  - Patients care plans were holistic, personalised and reflected the patients' views.
  - Staff in the service were dedicated, caring and understood the individual needs of the patients.
  - A full range of staff made up a skilled and dedicated MDT.
- However:
- Staff had implemented blanket restrictions in response to recent incidents. Many of the restrictions were common place on forensic wards due to associated security measures but needed to be reviewed on a regular basis in order to promote positive risk taking

# Summary of findings

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

### Are services safe?

#### We rated Forensic inpatient/secure wards good because:

- Wards were clean and well laid out with appropriate furnishings. Cleaning records were up to date and demonstrated the environment was regularly checked and cleaned.
- Care records contained contemporaneous and robust risk assessments.
- There were no incidents of seclusion in the previous 12 months as a result of a positive staff approach to de-escalation.
- There had been no never events in the previous 12 month period. There had been two serious incidents on different wards in August 2015; we saw evidence of embedded learning from these.
- Equipment was well maintained. Safety stickers on electrical equipment were in place and in date.

However:

- All wards, with the exception of Willow, had vacancies for registered nurses and for support workers.
- Décor and furnishings on Norton ward were worn and tired.

Good



### Are services effective?

- NICE (national institute of health and care excellence) guidelines were followed for prescribing of medicines & psychological therapies
- Staff followed good practice recommendations from 'Positive and Safe' (DH 2014) and the Mental Health Act Code of Practice (Ch. 26, 2015) in responding to challenging behaviour. Patients had positive behaviour support (PBS) plans in place to manage identified risks.
- Care records we reviewed contained up to date, personalised, holistic, recovery-oriented care plans. Care record documents were available in easy-read (accessible) format for patients with a learning disability on Ellesmere ward.
- Consent to treatment documents (T2/T3) clearly showed the appropriate e-BNF (electronic British National Formulary) sections.
- Patient outcomes were measured using recognised tools such as HONOS & 'My shared pathway'.
- Staff undertook clinical audits in areas such as care records, the provision of nursing 1:1 time, medicine management and the security of the environment.

Good



# Summary of findings

- Staff had forged effective working relationships with teams outside of the service such as social services and in primary care.
- Relevant trust policies were aligned with the Mental Health Act Code of Practice (2015).

However:

- Clinical supervision compliance was below the required standard. Managers were aware of this and had devised an action plan to improve the uptake.

## Are services caring?

- Patients told us staff were kind and caring. We saw staff treating patients with kindness and respect.
- Patients on Ellesmere ward had access to care record documents in easy-read (accessible) format.
- Patients were oriented to the wards when they are admitted.
- Patients' views are used in order to devise care plans and identified goals.
- Staff supported patients to use Skype to help them stay in touch with their loved ones.

Good



## Are services responsive to people's needs?

- All the wards included adjustments for people requiring disabled access.
- Interpreters were available for patients with sensory deficits and for patients whose first language was not English.
- Discharge plans were evident for all patients.
- Care record documents were available in easy-read (accessible) format for patients on Ellesmere ward.
- Patients' spiritual and cultural needs were met.
- There were a full range of rooms and equipment to support treatment and care available, these included clinic room to examine patients, gym, activity and therapy room.
- Patients were able to personalise their bedrooms to their own taste and preference
- Patients knew how to complain. Information about the complaints process was displayed on notice boards on all the wards.

Good



## Are services well-led?

- Staff knew and agreed with the trust's vision and values. We saw staff consistently demonstrating the values.

Good



# Summary of findings

- The trust use key performance indicators (KPIs) were used to measure performance.
- Clinical staff undertook clinical audits of care records, mental health act paperwork and mental capacity assessments.
- Learning from risk incidents and complaints was fed back to staff and acted upon.
- Ward managers had sufficient authority to recruit temporary staff to cover vacancies.
- Staff knew how to use whistle-blowing processes.
- Staff told us their morale was good and they had job satisfaction.
- The service participated in the Quality Network for Forensic Mental Health Services.

However;

- At the time of the inspection, there were a large number of vacancies across the forensic service. Managers were actively seeking to address these vacancies but acknowledge that competition for the available staff group from neighbouring trusts impacted upon their ability to recruit.



# Summary of findings

## Information about the service

- We visited two wards at the Redwood centre. Yew ward had 12 male beds and was a low secure admission and assessment ward and Willow was a low secure rehabilitation ward with 20 beds.
- At St George's hospital we visited 4 wards; these were Norton House which was a male medium secure rehabilitation unit with 12 beds, Radford House; a male medium secure admission and discharge unit with 16 beds, Ashley House a medium secure admission and discharge unit with 13 beds and Ellesmere House is a low secure unit with 12 beds for men of working age who have a learning disability.
- The role of the service was to provide a local, high quality, specialised and comprehensive forensic mental health service. The service is provided for mentally disordered offenders and others that will benefit from the service.
- This was the first comprehensive inspection of the trust, and core service, as part of our new approach to inspection.

## Our inspection team

The inspection was led by:

Lead Inspector: James Mullins, Head of Hospital inspections, Care Quality Commission

Chair: Vanessa Ford, Director of standards and governance, West London Mental health NHS Trust

The team that inspected the forensic inpatient/secure service consisted of: a lead inspector and two specialist professional advisors.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited six of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 23 patients who were using the service
- spoke with the 6 managers or acting managers for each of the wards
- spoke with 18 other staff members; including doctors, nurses psychologists, speech and language therapist and social workers
- interviewed the clinical director with responsibility for the services
- interviewed the professional head of forensic nursing

# Summary of findings

- attended and observed two hand-over meetings and three multi-disciplinary meetings.
- attended two patient community meetings
- visited the gym facility at the St George's hospital site
- visited the two seclusion facilities used by the service

We also:

- reviewed 16 medicine treatment records.
- reviewed 18 sets of care records.
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

- Patients all said they felt safe and all saw their nurse on a regular basis. One patient wanted us to know he was a regular complainer but wanted to see the CQC to tell us how good the overall service was.
- On Yew and Willow (low secure units) the patients said they felt the service was more like a medium secure unit.
- Patients told us there were good links made with their families
- Some patients across the wards said there was sometimes not enough staff on duty to enable all the activities and on Yew ward a patient told us there was not always access to fresh air.
- Overall, the patients were positive about their stay within the forensic services

## Good practice

- The staff approach to de-escalation was positive and had resulted in low levels of incidents and the minimal use of seclusion.

## Areas for improvement

### Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The trust should ensure all wards are staffed sufficiently to meet the needs of the patients and to manage any identified risks.

- The trust should ensure all staff access clinical supervision regularly.
- The trust should ensure all out of date consent to treatment forms are filed appropriately.
- The trust should ensure décor; fixtures and fittings are in good condition.

## South Staffordshire and Shropshire Healthcare NHS Foundation Trust

# Forensic inpatient/secure wards

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ashley Ward	St Georges Hospital
Ellesmere House	St Georges Hospital
Norton ward	St Georges Hospital
Radford ward	St Georges Hospital
Yew ward	The Redwoods Centre
Willow ward	The Redwoods Centre

#### Mental Health Act responsibilities

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

- Staff had a good understanding of the Mental Health Act and knew where to seek further advice.
- The Mental Health Act was part of their mandatory training and the training compliance was 85% overall.
- Staff understood the patient rights and understood the need to explain their rights to the patient on a regular basis.
- When people were detained under the Mental Health Act (1983), we saw the legal documentation for the treatment with medicines for mental disorder was completed accurately. We also found checks were undertaken at the multidisciplinary team meetings and also an audit was completed once a month by nurses to ensure the treatment documentation was in date and completed accurately.
- A mental health advocate was always available.

# Detailed findings

- Prescription charts had the relevant T2 or T3 form attached to them when required which were fully completed and correct.

However:

- In some prescriptions, old consent to treatment forms were still present; this could prove confusing to staff and presents a risk of incidents with medicines prescribing.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff showed a good understanding of the mental capacity act and could give a good explanation of the guiding principles.
- Care records indicated where staff had involved patients in making decisions about their treatment and care.
- The multidisciplinary team reviewed capacity and consent to treatment and discussed it in the multidisciplinary team meetings. Where a patient lacked mental capacity, the consultant psychiatrist recorded how they made decisions in their best interests.
- Staff had an understanding of Deprivation of Liberty safeguarding (DoLS) and on 5 wards it was not used. On the learning disability ward the DoLS had not been used in the period April 2015 to September 2015.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- Wards were clean and well laid out with appropriate furnishings. Cleaning records were up to date and demonstrated the environment was regularly checked and we observed cleaning taking place.
- Managers completed environmental risk assessments and ligature risk assessments on an annual basis. These assessments were up to date and were an accurate reflection of the environmental risks and ligature risks present. Staff took appropriate action in terms of levels of observation and individual risk assessments to mitigate risks. Trust policies and procedures supported staff to undertake these mitigating actions.
- Ligature cutters were available in case of an emergency and all staff were able to access them quickly in an emergency.
- The layouts of the wards enabled staff to observe the majority of areas. Where observation was restricted, we saw risk mitigation plans had been put in place; staff were placed at strategic points in order to enable observation of areas that could not be seen from a central area. The clinic rooms we reviewed were clean and tidy and well equipped. Resuscitation and emergency equipment was regularly checked and in date. Physical health equipment was present including a couch, scales and blood pressure monitors. Staff checked fridge temperatures daily to ensure the safe storage of medication. Emergency equipment was stored separately on yew ward. The emergency grab bag was kept in the main ward office while other equipment was stored in the clinic room. There was no signage to indicate this and in the event of an emergency, this could cause a delay for patients receiving assistance.
- Seclusion rooms were available for wards to access at both sites. The seclusion room on Yew ward allowed for clear observation. The seclusion room at St George's hospital was separated from the main ward and gave excellent provision for privacy and dignity. Both rooms had en-suite facilities and two way communication. Patients using the facilities were able to see a clock. We observed there were areas of limited visibility but this was mitigated by the use of CCTV.

- Staff adhered to infection control principles including hand washing. There was hand cleaning bottles on the entrances to and within ward areas. Staff were observed using these.
- Equipment was well maintained. Safety stickers on electrical equipment were in place and in date. This ensured the equipment was safe to use.
- On each ward, staff were given an alarm and set of keys at reception. These attached securely to staff by use of a buckle or belt. All staff had received training in key security prior to working on the wards.

### Safe staffing

- Senior clinical staff met every six months to review staffing requirements on the wards. The trust had a specific policy to guide this process. Ward managers reviewed the staffing levels daily and adjusted the levels according to need.
- As at 30th September 2015, staffing complements across the six wards varied. Ellesmere ward had a total staffing complement of 34; this included 15 registered nurses and 13.4 support workers. Norton ward had a total staffing complement of 31; this included 14.6 registered nurses and 10.9 support workers. Radford ward had a total staffing complement of 30; this included 16 registered nurses and 11.9 support workers. Willow ward had a total staffing complement of 33 which included 14.7 registered nurses and 9 support workers. Yew ward had a total staffing complement of 37 which included 14 registered nurses and 15 support workers. Staffing levels across the wards had been calculated against the acuity of the patients using the services.
- As at 30th September 2015, Ellesmere, Norton, Radford and Yew all had vacancies for registered nurses and for support workers. Radford ward had the greatest number of vacant posts with 5 registered nurse vacancies and 1.1 support worker vacancies. Willow ward had no vacancies for support workers and was one registered nurse above their staffing complement; Norton ward had 2.6 registered nurse vacancies and 0.9 support worker vacancies; Ellesmere ward had 3.4 support worker vacancies but was fully staffed with registered nurses and Yew ward had 1.1 registered nurse vacancies and 2 support worker vacancies.

# Are services safe?

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

- Ward rotas showed varying staffing levels on a daily basis on all six wards. Staffing levels were adjusted to meet the changing needs of the ward from day to day. Staff were allocated duties on the rotas such as nurse in charge, group work, security nurse and cover for meetings that the ward manager attended.
- Staff leaving the service in the time period August 2015 - October 2015 were as follows; 10 (13.3%) leavers from Radford, five (16.1%) leavers from Norton, four (9.5%) leavers from Ashley, seven (21.2%) from Willow and three (8.1%) from Yew.
- In the period October 2014 to September 2015 staff sickness was as follows; Ellesmere had 5.2% sickness, Norton had 5.2%, Radford had 4.3%, Willow had 6% and Yew had the highest ratio with 6.6%.
- Managers were able to recruit additional temporary staff from the trust bank to cover for any vacancies. In the period August 2015 - October 2015, Ellesmere had 66 shifts which were covered with temporary staff. Norton had 181 shifts with vacancies and were unable to cover seven of those with temporary staff; Radford had 20 shifts with vacancies and were unable to cover two of those; Willow had 113 shifts with vacancies and were unable to cover 12 of those; Yew had 110 shifts with vacancies and were unable to cover three of those shifts.
- Each ward acknowledged they sometimes experienced challenges in reliably providing scheduled activities due to staffing shortfalls. The trust were aware of this and were seeking to address it as a matter of urgency through additional recruitment drives.
- All temporary staff had been inducted to the ward before working with the patients. Temporary staff were regular to the wards and were therefore familiar with the environment and the patient group.
- Staff and patients on each ward told us there was always a qualified nurse available in the main ward area.
- Staff and patients told us they had regular 1:1 time and this was monitored through supervision and by audit from the senior staff on each ward.
- The ward rotas showed there were always enough staff to safely carry out physical interventions
- On all wards, there was a doctor available during normal working hours. Outside of these hours, there was a doctor on call who would be available to attend or for advice.
- The average rate of mandatory training completion was 84%; Willow ward had the lowest overall compliance at 75% compared with the trust target of 85%. The trust had an action plan in place to address the lower compliance levels of mandatory training completion.

## Assessing and managing risk to patients and staff

- There was one incident of seclusion in the 12 months prior to our inspection: this was for 1 day on Yew ward. Prior to this, the last date seclusion was used was in March 2015 and was for a period of 14 days on Yew ward. Seclusion records were filed in the appropriate section of the care records and demonstrated nursing and medical reviews had been undertaken in line with the Mental Health Act Code of Practice (2015).
- In total, across the entire service, restraint had been recorded and reported on 45 occasions and involved 9 different patients. Ellesmere had the highest amount of restraints; between April 2015 - September 2015, there had been 32 reported episodes of restraint involving 4 patients. There were no episodes of prone restraint reported within this time period. Staff were skilled at de-escalation and were able to defuse most incidents of challenging behaviour without needing to use physical restraint.
- The use of rapid tranquilisation followed NICE guidance. We looked at the medicine records for one patient who had been given a medicine by this route. The rapid tranquillisation policy had been followed with observations and clinical checks being recorded to ensure the safety and well-being of the patient.
- We reviewed 18 sets of care records. Staff used recognised assessment tools which were accessed via the trust electronic record system called RIO. The RAF 1 (risk assessment framework), the START (short term assessment of risk and treatability) and the HCR 20 (Historical clinical risk) were all used by the service. Risk assessments were undertaken prior to and on admission. The HCR20 was completed at the first CPA meeting and START assessments are also used.
- Staff implemented blanket restrictions on all six wards in the service. Blanket restrictions are where restrictions were applied to all patients regardless of their risk status. The blanket restrictions in place related to risk and included no free access to personal care items such as aerosols, electric toothbrushes and manicure equipment. Patients could access such items under staff supervision. Smoking was not allowed in any of the trust

## Are services safe?

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

properties or accompanied leave. On Yew and Willow wards, all patients were subjected to a pat down search (search of a person's outer clothing wherein a person runs his or her hands along the outer garments to detect any concealed prohibited items) when returning from leave. Routine room searches were undertaken; use of mobile phones whilst on the ward was restricted. As a consequence of having to comply with a pat-down search on return from leave, patients had to return from unescorted leave either on the hour or on the half hour. Managers said staffing the pat-down searches for patients returning from leave was less problematic if patients returned from leave at these set times. We had a discussion with the senior management team and they were aware of the restrictions. They said it was in response to lessons learned from previous risk incidents. The restrictions had been in place for six months and were based on identified potential risks. There were plans underway at the time of the inspection to review the restrictions.

- Patient access to the secure outside space was restricted. They could access the secure outdoor space four times a day for 30 minute periods. Staff on all six wards would try to facilitate additional access to fresh air when patients requested it, but this was often not possible due to insufficient staff to maintain safety.
- Children visiting the service had their visits facilitated in a designated visiting room away from clinical areas.
- Staff were trained in Safeguarding procedures. They knew how to identify the different types of abuse and how to report it. Staff know who they can contact for advice or support about Safeguarding issues.

- Staff managed and stored medicines in line with trust policy. Clinic room and medicine fridge temperatures were measured daily. Controlled medicines were stored appropriately in a separate locked cupboard within the main locked medicine cupboard. A pharmacist visited the wards each week to carry out an audit of the management of medicines.

### Track record on safety

- There had been no recorded never events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There had been two serious incidents reported in the 12 months prior to our inspection; one on Willow ward and one on Ellesmere house. Both incidents had been investigated using a root cause analysis process.

### Reporting incidents and learning from when things go wrong

- Staff reported all risk incidents and near misses on an electronic recording document. All staff were aware of the procedure for recording and reporting risk incidents and near misses.
- Managers fed back learning from incidents to staff in monthly staff meetings and in clinical supervision.
- Managers implemented changes in practice following lessons learned from incidents by altering observation levels and re-structuring ward handovers. Re-structuring ward handovers improved communication between staff teams and improved the quality of the information.
- Staff told us they receive supportive debrief following any serious incidents



# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- We reviewed 18 patients' care records across the six wards. Care plans were up to date, personalised, holistic, recovery-oriented. Patients had participated in comprehensive assessments of their various needs on admission to the service. Where patients had declined the opportunity to participate in care planning, this had been recorded in the care record in all but two cases.
- Patients had been provided with a physical health assessment on admission. There was evidence of ongoing monitoring of physical health. Staff implemented the Early Warning Score tool (EWS) to monitor patients' vital signs such as blood pressure, pulse and temperature.
- Patients on Ellesmere ward had health action plans. Care record documents on Ellesmere ward were available in easy-read (accessible) format.
- Patients had their preferences in terms of how staff should try to respond to any disturbed behaviour recorded on their positive behaviour support (PBS) plan.
- Staff maintained care records securely. Hard copies were stored in lockable cabinets in the nursing office and electronic care records required a secure password for access.

### Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance for the short term management of violence and aggression in healthcare settings (NG10). This guidance promotes the use of de-escalation techniques to manage incidents of disturbed behaviour.
- Staff followed NICE guidance around prescribing practice wherever possible. Some patients were prescribed anti-psychotic medicine that was above the limits set out in the British National Formulary (BNF). These prescriptions had been reviewed and approved by a second opinion approved doctor (SOAD).
- Consent to treatment documents (T2/T3) clearly showed the appropriate e-BNF (electronic British National Formulary) sections.
- Psychologists provided psychological therapies such as cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), anger management, sex offender treatment programme and violence reduction.

Psychological therapies were delivered in group work and individually. The trust had a CQUIN (Commissioning for Quality and Innovation) in place around the provision of psychological therapies. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

- Speech and language therapists (SALTs) had created easy-read (accessible) versions of care record documents for patients on Ellesmere ward.
- Patients on Ellesmere ward had communication passports to support ease of communication in any alternative healthcare setting.
- Patients' were registered with a local GP and were referred to any specialist medical services as required.
- Staff used the Health of the Nation Outcome Scale to measure patients' progress and outcomes.
- Staff undertook clinical audits such as care records, the provision of nursing 1:1 time, medicine management and the security of the environment.

### Skilled staff to deliver care

- Multidisciplinary teams on the six wards had a full range of mental health disciplines including nurses, doctors, occupational therapists (OTs), psychologists, pharmacists, social workers and speech and language therapists.
- Staff were suitably experienced and qualified.
- Staff attended a trust wide induction upon commencement of employment. In addition to the trust induction, staff working within the forensic service were also provided with a specialist induction. This induction would cover topics such as security and the secure and safe management of keys.
- Staff uptake of clinical supervision was poor. Managers were aware of this and had included the improvement required in the service action plan. We saw there had been some improvement in the uptake of clinical supervision since its profile was raised on the action plan.
- Between April 2015 to September 2015, appraisal figures varied from 62% on Willow ward and 89% at Ashley House.
- Underperforming staff were appropriately performance managed as per the trusts' HR policies and procedures.



# Are services effective?

Good 

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

## Multi-disciplinary and inter-agency team work

- Multidisciplinary teams met weekly to discuss care and treatment for individual patients.
- The pharmacist attended MDT meetings and reviewed the medicines management.
- Staff recorded information given at handovers in specific handover books. This meant staff could refer to the handover book if they wanted to check any information during their shift.
- As patients progressed towards discharge from the service, care coordinators and other community agencies such as accommodation providers would be invited to attend MDT meetings and care programme approach (CPA) meetings. Some patients did not progress toward discharge and instead required referral to alternative secure services. In this situation, staff from the new service would attend MDT meetings and/or CPA meetings as appropriate.
- Staff had effective working relationships with teams outside of the service such as social services and GPs. Ellesmere ward had particularly a good relationship with the local authority Safeguarding team.

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

- Trust policies were aligned with the changes incorporated in the Mental Health Act Code of Practice (2015).
- Eighty three per cent of staff across the six wards were up to date with mental health act training. Staff we spoke with demonstrated a good understanding of the mental health act, the mental health act Code of Practice (2015) and the guiding principles of least restrictive option, empowerment and involvement, respect and dignity, purpose and effectiveness and efficiency and equity. We saw staff working to these principles during our inspection.
- Clinical staff undertook audits of care records including mental health act documents. Staff knew how to contact the mental health act administrator in the trust if they required advice or guidance on any matters relating to the mental health act.
- Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medicine charts where applicable.

- Care records demonstrated people had their rights under the mental health act (MHA) explained to them on admission and routinely thereafter.
- Staff could seek advice and guidance on the MHA from the trust Mental Health Act administrator. All staff were aware of how to contact the Mental Health Act administrator.
- Staff ensured detention paperwork was filled in correctly, up to date and stored appropriately.
- Patients had access to independent mental health advocates (IMHA) whenever they wished. Information about this service was displayed throughout the wards on notice boards.
- Mental health act commissioner visits in 2014 and 2015 identified problems with consent to treatment documentation. At the time of our inspection, all consent to treatment documents were up to date and accurate.

## Good practice in applying the Mental Capacity Act

- The trust had a policy in place to guide staff in administering the mental capacity act.
- Eighty three per cent of staff across the six wards were up to date with mental capacity act training. Staff we spoke with demonstrated a good understanding of the act and could explain the five guiding principles relating to the presumption of capacity, supporting patients to make their own decisions, patients having the right to make unwise decisions, acting in a patient's best interests, how to undertake a best interests assessment and how to care for people using the least restrictive option to manage any identified risks.
- Clinical staff undertake audits of mental capacity assessments.
- There had been no deprivation of liberty safeguards (DoLS) applications made in the 12 months prior to the inspection.
- Capacity to consent is assessed and recorded appropriately. This is done on a decision-specific basis with regards to significant decisions and people are given every possible assistance to make a specific decision for themselves before they are assumed to lack mental capacity.
- Staff understand and where appropriate work within the MCA definition of restraint.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- Patients told us staff were kind and caring.
- We saw staff treating patients with kindness and respect. Staff treated people with respect and upheld their dignity.
- Staff understood the individual needs and preferences of the patients in their care.

### The involvement of people in the care they receive

- Patients are oriented to the wards when they are admitted. They are provided with an admission booklet which contains information about the ward, the ward routine and signposts patients to resources they may wish to use.
- Patients had access to advocacy services.
- Patients are encouraged to maintain contact with their friends and families. Some patients families live long

distances from the hospital and are unable to visit frequently. In these types of situation; staff support patients to use Skype to help them stay in touch with their loved ones.

- Patients could provide feedback about the service at weekly community meetings.
- Patients attended 'morning meetings' each morning. At the meetings they would negotiate which activities would take place on the day such as Section 17 leave, or other meaningful ward based activities such as cooking or games.
- Patients jointly filled in START risk assessments with staff to identify their risks and devise strategies to minimise their risks. Most patients told us they had contributed their views to their care plans and we observed this at MDT meetings.
- Patients had access to easy-read (accessible) documents on Ellesmere ward.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- Average bed occupancy was 94.16% across the 7 wards in the period April 2015 to September 2015. Ellesmere and Yew had the highest bed occupancy at 98% with the lowest on Radford at 91%.
- Norton ward had three delayed discharges in the period April 2015 to September 2015. Radford ward had two delayed discharges in the same time period. There were no delayed discharges on the other five wards in the same time period.
- Yew ward had one re-admission within a 90 day period in the time period April 2015 to September 2015. Norton ward had one re-admission within 90 days in the same time period.
- Due to the nature of the services discharge arrangements varied across the wards but were well planned with patient involvement. We saw links had been made with community services, prisons and other hospital wards to help in the planning of a patients discharge.
- Patients were involved in their discharge plans through their care plans and multi-disciplinary meetings.
- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and was in the best interests of the patient.
- When people were moved or discharged this happens at an appropriate time of day.
- Staff on Ellesmere ward followed the guidance in the 'Transforming Care' document (NHS England 2015). This document supports teams having a focus on discharge throughout a patient's admission.
- A bed was always available in the forensic service intensive care ward if a patient's risks require additional staff support to help them stay safe.

### The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and equipment to support treatment and care. These included clinic room to examine patients, activity and therapy rooms. There

- was a fully equipped gym off the ward as well as a dedicated activity room. The gym was staffed by a qualified gym instructor; patients underwent a physical health assessment prior to accessing the gym.
- Patients could access quiet areas if they wished. Family visiting rooms were available to all patients.
- All the wards provided dedicated telephone facilities. These were either an enclosed telephone booth or a wall mounted telephone with a sound dampening hood to provide privacy to the caller.
- Patients may access the secure outdoor space on request
- Patients told us the food was of good quality but the choice was often limited. The 2015 PLACE scores for Food for St George's and the Redwoods Centre were; 94.65 and 91.52 respectively. These scores included forensic wards.
- Patients can access snacks and drinks 24 hrs a day, seven days a week. One of the wards would lock the kitchen area due to risk unless staff were available to supervise. At these times, patients could get drinks from a drinks machine which was free of charge to use.
- Patients were able to personalise their bedrooms to their own taste and preference provided no risk items were included in the décor.
- Patients were provided with 25 hours of activities each week. Activities included social outings such as cinema trips as well as activities directed at improving activities of daily living such as shopping, cooking and budgeting.

### Meeting the needs of all people who use the service

- All the wards included adjustments for people requiring disabled access.
- Information leaflets relating to advocacy services, patients' rights under the Mental Health Act 1983 and complaints procedures were displayed on all wards. The leaflets were available in languages other than English.
- Easy-read (accessible) versions of care record documents were available to patients on Ellesmere ward.
- Staff were able to access interpreters for non-English speaking patients and signers to facilitate communication with deaf patients.
- Patients' dietary requirements in relation to religious or ethnic groups were catered for.

# Are services responsive to people's needs?

Good 

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

- Patients had access to multi-faith rooms to practice their spiritual beliefs. Staff could access spiritual support from various faiths if patients wished.

## **Listening to and learning from concerns and complaints**

- A total of 4 complaints were received in the period April 2015 to September 2015. One of these complaints was fully upheld and three were partially upheld. No complaints were referred to the parliamentary and health services ombudsman.
- Patients knew how to complain. Information about the complaints process was displayed on notice boards on all the wards. Advocacy services could help and support patients to make complaints.
- Patients' complaints were investigated locally and the outcome fed back to the patient. If a patient was not satisfied with the response to their complaint at ward level then their
- complaint would be escalated to the complaints department.
- Managers communicated any learning for future practice from these complaints to staff at staff meetings and in clinical supervision.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- Staff know and agree with the trust's vision and values. We saw staff displaying the trust's vision and values as they went about their work. The trust has one 'vision' which is "To be positively different through positive practice and positive partnerships". To achieve this vision, the trust expected to see five behaviours displayed by staff. These behaviours are to be respectful, to be honest and trustworthy, to be caring and compassionate, taking the time to talk and listen; and to work together and lead by example. The values were to put people at the centre of their care and to accomplish this by valuing staff and valuing the partnerships the service had with patients, carers, commissioners of services and other service providers.
- Staff knew who the most senior managers are in the organisation. These managers were a visible presence in the service and visited the wards.

### Good governance

- The trust used key performance indicators (KPIs) to measure the team's performance

and had developed action plans to address areas of poor performance.

- Core mandatory training uptake across the service averaged 84%. This was very close to the Trust target of 85%. There were action plans in place to further improve training compliance across the service.
- The wards used clinical audits to monitor how effectively they were providing care. Audits were carried out by different staff for many activities including management of the mental health act and mental capacity assessments, care plans, medication management, the provision of nursing 1:1 time and security of the environment.
- Nursing vacancies across the service were 16 registered nurse and 11.3 support worker vacancies. These vacancies meant a total of 670 shifts in the period August 2015 to October 2015 required temporary staff to cover. Of these 670 shifts, 30 could not be covered by temporary staff. The trust acknowledged there were deficits in staffing and were undertaking recruitment drives in order to address this.

- All services had a good mix of professionals including administration staff; this allowed staff to spend more time on direct patient care activities.
- Ward managers said there were sufficient safe staffing across all shifts and they had the authority to increase their staffing levels when acuity increased.
- Staff could submit items to the trust's risk register.
- Staff uptake of clinical supervision and appraisal had been poor. Appraisal and supervision rates for each service were being monitored monthly. Senior Managers were aware of this and had included the improvement required in the service action plan. We saw there had been improvement in the uptake of clinical supervision since its profile had been raised on the action plan.
- Staff learning from incidents, complaints and service user feedback was evident. Learning was communicated to staff in staff meetings and in clinical supervision.

### Leadership, morale and staff engagement

- Multidisciplinary team working was effective. All team members were able to contribute to care plans.
- Staff were provided with a de-brief following any significant incidents. The nurse in charge of the ward facilitated the de-brief. The nurse in charge was debriefed by the ward manager at the earliest opportunity.
- Staff sickness rates were 6% or less for the 12 month period until and inclusive of February 2016.
- The trust had developed a leadership developmental programme. Staff that were involved said they had good support from senior managers. There were also opportunities for unqualified staff to attend university to gain qualified status.
- There had been no incidents of bullying or harassment.
- Staff told us they feel able to raise concerns without fear of victimisation.
- Staff were aware of the trust's policy on the Duty of Candour. They could fully explain and demonstrate knowledge of duty of candour.
- Staff knew how to use whistle-blowing processes. Staff told us they were confident managers would listen to concerns without them having to implement whistle-blowing processes
- Staff told us their morale was good and they had job satisfaction.
- Staff could provide feedback to the service by way of staff meetings or through the staff survey.

# Are services well-led?

Good 

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

## **Commitment to quality improvement and innovation**

- Senior managers had signed the service up to the Quality Network for Forensic Mental Health Services.  
The Quality Network for Forensic Mental Health Services

adopts a multi-disciplinary approach to quality improvement in medium and low secure mental health services. A key component of the work is the sharing of best practice; by listening to and being led by frontline staff and patients.