

Pennine Care NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

225 Old Street
Ashton-under-Lyne
Lancashire
OL6 7SR

Tel: 0161 716 3877

Website: www.penninecare.nhs.uk

Date of inspection visit: 14 -15 June 2016

Date of publication: 09/12/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RT202	Tameside Mental Health Services	Tatton Unit	OL6 9RW
RT204	Rochdale Mental Health Services	Prospect Place	OL12 9QB

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

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

Where applicable, we have reported on each core service provided by Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care 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

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	10
Our inspection team	10
Why we carried out this inspection	10
How we carried out this inspection	10
What people who use the provider's services say	11
Areas for improvement	11

Detailed findings from this inspection

Locations inspected	12
Mental Health Act responsibilities	12
Mental Capacity Act and Deprivation of Liberty Safeguards	12
Findings by our five questions	14

Summary of findings

Overall summary

We rated forensic inpatient/secure wards as **good** because:

- the wards were bright, clean and well equipped. Patients' rooms were en suite and they had ample space to store their belongings.
- There were good security systems in place and these were appropriate for a low secure inpatient environment.
- The trust were continuing to address least restrictive practice and were regularly reviewing rules and blanket restrictions on the wards.
- Patients had multidisciplinary team involvement and access to evidence based interventions. Staff had the right qualifications and access to a range of training.
- Care plans were comprehensive and reviewed regularly.
- All the wards had a range of activities available seven days a week and including some evenings. Many of the activities took place within the local community and included access to education and training.

- There was clear leadership in the service. Managers knew what was going on within the wards and were known to both staff and patients.
- Staff engaged in a range of audits and were using the outcomes of these to review how effective their service was and to look for ways to improve.

However:

- There were staffing pressures at Prospect Place. Managers were not meeting with staff to undertake an exit interview.
- Many patients expressed dissatisfaction with the choice of food that was provided. Patients told us this made the food choice boring and did not offer much real choice if someone disliked the main meal options that were repeated regularly
- Staff facilitated garden access every two hours at the Tatton Unit. Staff were unclear why there was no unrestricted access to the outdoor area.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Care plans and risk assessments were of a good quality. They were regularly reviewed.
- The ward environments were bright and clean and felt spacious and airy. The furniture and décor were well maintained and there was good access to outdoor areas.
- There were good security systems in place. These included appropriate low secure boundary fences, good systems for the management of keys and the supervision of patients within the units.
- A staff member was allocated the role of security lead on every shift.
- All staff had a good knowledge of the principles of relational security. They understood the importance of least restrictive practice and reduction of blanket restrictions.
- The use of seclusion and restraint within both the units was low in comparison to other similar services. The trust monitored and reviewed all incidents and shared details of these within the service. This ensured staff were aware of key themes and any lessons learned from more serious incidents.
- The wards had the right number of appropriate qualified staff. Although bank and agency staff were being used on a regular basis at Prospect Place the trust were actively recruiting to all vacancies. Charge nurses on the wards were taking appropriate action to reduce staff sickness level.
- There were good communication systems in place on all the wards. These include effective handover processes between staff completing a shift and new staff coming on duty. There was good use of white boards in all staff offices to ensure staff were appraised of key information, risks issues and tasks that required completion.
- There were good systems in place to ensure that food was being stored appropriately, emergency equipment was in good working order and infection prevention requirements were followed.
- There was adequate medical availability from consultant psychiatrists, more junior doctors and attending GPs.
- The majority of staff were compliant with the trust mandatory training requirements. Where these figures were lower than the trust target charge nurses and unit managers explained the process that was in place to ensure all required staff were to be trained as required.

Good



Summary of findings

- Staff had a good knowledge and understanding of safeguarding. They knew what types of incidents should be reported and they understood how to do so.
- There were effective medicine management systems in place. Nursing staff undertook medicine competency assessments. Pharmacy staff attended all of the wards regularly and provided support to the nursing and medical staff. In addition pharmacy staff undertook regular audits of compliance with policy and safe medicine management and informed the charge nurse of any concerns. This ensured concerns were followed up directly with staff involved.

However:

- There were separate clinical records completed by the doctors and the remainder of the multidisciplinary teams. This meant clinical details were being held in two different files. The trusts were intending to move to one electronic clinical record. Some pilot sites at the trust were testing out the new system.
- Patients could not go in to the garden without staff supervision at the Tatton Unit. There was supervised access every two hours. Staff were not sure why access could only be supervised.
- There were staffing pressures at Prospect Place. Managers were not meeting with staff to undertake an exit interview when staff were leaving their job.
- Sickness levels were higher than the national average , although we were told there were not high levels of work related sickness.

Are services effective?

We rated effective as good because:

- There were comprehensive physical health care assessments and interventions being carried out. These were reviewed and discussed at the regular clinical review meetings.
- Staff were providing evidence based interventions that reflected best practice.
- Although this was a low secure service there was work in place with community services, such as Rochdale training and development services. Patients were attending training in a work environment within the local community.
- There was good access to a range of psychological interventions on each of the wards. In addition, some patients were attending specialist therapy groups at other mental health trusts. This was to ensure they had access to the best possible therapy and interventions.

Good



Summary of findings

- Many of the patients were self-medicating despite their having no imminent discharge plan in place. This enabled patients to maintain their independence.
- The wards had the right types of staff delivering the right types of interventions and support.
- Staff received a good quality induction when they first went to work on the wards.
- All staff had an up to date annual appraisal and a subsequent personal development plan. Staff told us they were encouraged by their managers to access appropriate training. They felt supported in their personal development.
- All staff were receiving line management supervision in line with the trust policy. The trust policy meant clinical supervision was included as part of line management supervision. However, staff were also encouraged to access additional individual and peer support type supervision.
- There were effective clinical review meetings and these were attended by the multidisciplinary teams.
- Handovers between shifts was of a good quality and ensured that communication within the staff team was good.

Are services caring?

We rated caring as good because:

- Patients described that the staff were kind and respectful and worked hard to help them
- We observed staff to be courteous, respectful and kind
- There was good attendance by the patients at the community meetings held on the wards. Patients told us they felt confident to raise issues and concerns at those meetings. They were confident action would be taken.
- The mental health advocates attended the wards often and were well known to both the staff and patients

Good



Are services responsive to people's needs?

We rated responsive as good because:

- There was not a long waiting list of people to be admitted. This meant patients were not delayed in accessing the service when an assessment had been completed.
- Plans toward discharge were reviewed at clinical meetings. Barriers toward any possible discharge were also discussed and plans made to try to address these.

Good



Summary of findings

- Specialist secure commissioners attended review meetings regularly. They supported the patient and the inpatient staff to identify the most appropriate next stage accommodation or inpatient facility.
- Prospect Place had four rooms that had been adapted into accommodation that was more independent. Patients working toward discharge were able to move to a more independent room and begin using their own activities of daily living skills more in preparation for moving to their own flat at discharge.
- The inpatient areas were bright and airy with access to outdoor space. There were a range of facilities including lounges and quiet rooms and rooms where groups and individual sessions with staff could be held.
- Patients confirmed that they knew how to complain if they wished to. There were very few actual complaints made. Some patients raised issues with us on the day of the visit. We asked the charge nurses to follow these up on the day.

However:

- Many patients expressed dissatisfaction with the choice of food that was provided. Patients told us this made the food choice boring and did not offer much real choice if someone disliked the main meal options that were repeated regularly.

Are services well-led?

We rated well-led as good because:

- The trust had a clear vision and strategic plan. Staff working in the low secure service were aware of these. Individual staff appraisals and objectives for the coming year were mapped against the trust goals.
- Staff told us they felt well supported by their managers. They felt they were given enough authority to be able to do their own work but managers were available to support and assist.
- There was clear leadership in place from the charge nurses and unit managers. At Prospect Place the unit managers were based within the actual inpatient ward. Managers knew the patients and were fully aware of what was happening within the wards.
- Staff were receiving annual appraisals and regular supervision. The majority of staff were compliant with required mandatory training.
- It was rare for the wards to be short staffed. Where there were vacancies the trust were seeking to recruit in to them. Bank and agency staff were used to ensure the wards were not short staffed.

Good



Summary of findings

- The low secure services undertook a range of audits. These included audits by staff based within the unit such as psychology staff or nursing staff reviewing the impact of a new initiative. Directorate wide audits aimed to ensure that minimum standards were being maintained in areas such as care planning, risk assessment and ensuring full compliance with the Mental Health Act and the Code of Practice. The low secure services were also part of the quality network for forensic services and had received their first peer led audit.
- There were good systems in place for notification of incidents. Staff knew what to report and how to do so. There were governance structures in place where lessons learned were cascaded to staff with the service so they were aware of how practice may need to change.

Summary of findings

Information about the service

Forensic inpatient services were part of the trust's Specialist Services Division. This directorate provided low secure and step-down services. These services worked alongside the trust rehabilitation and high support directorate. There was a care pathway within the low secure services and into the rehabilitation step-down inpatient services.

Low secure inpatient services were located in two units. Prospect Place was in Rochdale and Tatton Unit was in Tameside. Prospect Place could accommodate 45 male patients. There were three wards. Assessment ward had 13 beds, Recovery ward had 15 beds and Social Inclusion ward had 17 beds.

Each had its own admission and discharge criteria. Patients were admitted to the assessment ward. Throughout the course of their inpatient stay patients moved to the recovery ward and finally the social inclusion ward prior to discharge. Admissions to the care

pathway were expected to be for two years. Tatton Unit had 16 beds and provided a longer admission pathway of three to five years. Both units were for males aged from 18 years. All patients were detained under the Mental Health Act 1983.

The majority of the patients had been admitted as part of the step-down care pathway from medium secure inpatient units. Other admissions were prison transfers and from acute inpatient units such as psychiatric intensive care units. The trust clinical pathway team assessed all referrals to male low secure services. In addition to agreeing appropriate admissions, this team maintained contact with the individual patients during their time on the unit and following discharge to other services in the rehabilitation care pathway.

The trust had no low secure beds for women. These were provided by another mental health trust.

Our inspection team

The inspection was led by:

Chair: Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nick Smith, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team that inspected forensic inpatient/secure wards comprised a Care Quality Commission inspector and an inspection assistant, a Mental Health Act reviewer, two mental health nurses, and a specialist pharmacist.

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 this service and asked a range of other organisations for information.

Summary of findings

During the inspection visit, the inspection team:

- visited both low secure units on two hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients
- spoke with the managers of each of the wards
- spoke with 31 other staff members; including doctors, nurses, occupational therapists, psychologist, pharmacist, social workers, and housekeeping staff
- spoke with two independent mental health advocates
- attended and observed two multi-disciplinary team meetings
- looked at the treatment records of 12 patients. These included care plans, risk assessments, and Mental Health Act paperwork
- carried out a review of medication management at both hospital sites
- 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 told us that the staff were good and worked hard to assist them. Some patients told us that they felt safe on the wards. However, two told us they did not feel safe due to how unsettled the ward at Prospect Place was.

They said that staff reacted quickly if there were problems. Patients said there were adequate numbers of staff although they found it frustrating if leave was cancelled at short notice if there were problems.

Patients told us they were confident that they were receiving the right care and treatment. Patients had access to their named nurses to have one to one

discussions. This included for their physical health problems. Patients felt involved in their care and able to express their views. They said they were listened to at their monthly clinical review meetings. They said the process of admissions had built their confidence about being admitted. The process had made them feel staff understood that their views were important.

This was not the view of all patients however. During the visits, we escalated complaints that were made and asked the senior managers to look into, and respond to, the patients wishing to complain.

Areas for improvement

Action the provider SHOULD take to improve

- The staff at Prospect Place should ensure compliance with required mandatory training at the earliest opportunity.
- The trust should review the availability of Mental Health Act refresher training for staff.
- The trust should continue to address the concerns being raised by patients regarding the choice of food.
- The trust should review the restrictions to the garden at the Tatton Unit.
- The trust should ensure exit interviews are conducted with staff who are leaving their posts. This will enable managers to look into any concerns that the staff leaving may raise.

Pennine Care NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Tatton Unit

Prospect Place

Name of CQC registered location

Tameside Mental Health Services

Rochdale Mental Health Services

Mental Health Act responsibilities

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

All required Mental Health Act documentation was in place within clinical records. There were good quality risk assessments and evidence of additional ones undertaken prior to patients taking leave from the wards. Staff reviewed how leave had gone with the patient on their return. Staff were regularly discussing individual patients' rights with them and documenting that this had occurred. We did not see any completed advanced statements in the clinical records. However, individual wishes and aspirations were being recorded within the 'my shared pathway' documents that were being completed for all patients.

There were good systems in place that were overseen by a Mental Health Act administrator. These systems provided

prompts and reminders to clinical staff to ensure all responsibilities under the Act were completed. Independent mental health advocates were regularly on the wards and their role and support was established.

One of the seclusion facilities was in use during our visit and it was therefore not possible to review the premises. What was seen appeared to comply with national standards. The paperwork for the episode of seclusion in process met trust policy and complied with expectations within Code of Practice. No central log of previous seclusion episodes was available for review however and we were told these were located within individual patients' clinical records.

Some nursing staff told us they had not been able to access Mental Health Act training in the previous 12 months. Despite this staff had a good knowledge of the Act,

Detailed findings

including the Code of Practice. We received positive feedback from the independent mental health advocates who maintained regular and proactive contact with patients on each of the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

All of the patients within the forensic low secure services were detained under the Mental Health Act. No patients were detained under Deprivation of Liberty safeguards.

At the time of this inspection 77% of the staff within the forensic low secure services had completed Mental Capacity Act training. Staff had a good knowledge of the core principles of the Mental Capacity Act.

There were policies in place that staff could refer to if required.

Are services safe?

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

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

Our findings

Safe and clean environment

There was an air lock at the entrance to Tatton ward and one to access Prospect Place. There were staff stationed in the reception area overseeing the entrance and exit to the wards. These staff also managed keys and general security. CCTV footage of the reception area and main corridors was available to review if required. CCTV was not constantly monitored. At both units, the airlock opened into a corridor leading to the main ward areas. Patients were always supervised in these areas.

The wards in the low secure service were for men. All of the areas were clean with good furnishings and were well maintained. We saw the cleanliness monitoring audits that were undertaken on a monthly basis. The outcomes of these were sent as a board report

The corridors were bright and spacious and the bedroom areas were separate from the main lounges and dining areas. We saw that the television in the main lounge on one ward at Prospect Place was not fully working and the public telephone was not working. We were informed that these had both been reported approximately two weeks previously. Patients had their own televisions in their rooms and had access to their own mobile phones.

There were good systems in place for the management of security and provision of keys. All staff understood the security policies. Staff described to us the importance of quality relationships with patients as part of requirements for relational security in a low secure forensic unit. There were nurse call systems throughout the ward. All staff carried a personal call alarm. Agreements to respond to neighbouring wards were in place in the event of alarms being activated.

There was an up to date environmental risk audit completed for each of the wards. Each ward had a ligature risk audit completed in 2016. These indicated a score rating for the higher risk ligature points within the wards and detailed strategies for reducing those risks. Staff knew where the ligature points were on the wards and were able to describe measures in place to reduce the risks from

them. Additional environmental risk assessments and associated risk reduction strategies were completed for a range of group and individual activities. These included cooking, music, art and sports groups.

Full vision along the length of corridors within the wards was inhibited by curved corridors. Staff demonstrated how they used the concave mirrors already in place to improve the vision around the curved corridors. Staff confirmed there had never been any incidents associated with the reduced corridor length view.

We reviewed the clinical rooms on each of the wards we visited. These were clean and well stocked. We saw where daily checks were required these were undertaken. On two occasions the daily checks had not been completed. The senior nurses on the ward took action and addressed this with team members via the team meetings.

There were seclusion facilities at both Prospect Place and the Tatton Unit. The Prospect Place suite was used by the three wards. It was not possible to review the facility during this inspection as it was in use. Care Quality Commission were satisfied with facilities on previous visits. Staff had the means to communicate with patients in the seclusion room and with other staff on the ward. The seclusion suite had access to a small outside area where patients could get fresh air in a small courtyard area. The Tatton Unit seclusion suite had never been used. We viewed the provision during our visit. It complied with the Mental Health Act Code of Practice requirements.

Patients told us that the domestics were hard working and that their rooms and wards were always kept clean and well maintained.

There were posters and reminders to promote safe hand washing practices. Each ward had an infection prevention lead. These staff had additional training to undertake this role. They ensured that a quarterly hand hygiene audit, a six monthly environmental checklist audit and a monthly cleanliness audit was undertaken on each ward. At the most recent audits each of the wards within the low secure services had scored between 97 to 100% in the bare below the elbows and the hand hygiene audits.

Each of the wards were required to monitor the fridge temperatures on a daily basis in both the main kitchen and

Are services safe?

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

where patients could store their own food. These had not been completed on every occasion in the two weeks prior to the inspection at Prospect Place. We informed the manager of this during the visit. They agreed to review why the checks had not happened and ensure they were completed daily as required.

Safe staffing

The figures from the trust provided the following detail about staffing. There was a combined total of 44.8 whole time equivalent qualified nurses across the low secure services. At the time of inspection, there were 7.2 whole time equivalent vacancies for qualified nurses. These vacancies were equally split between wards at each site. There were a total of 48.4 whole time equivalent health care assistant posts. There were six whole time equivalent vacancies for health care assistants, five of which were on the wards at Prospect Place. Charge nurses were based on each ward and they were in addition to the staffing numbers.

Agency and bank staff were employed to cover the vacancies in staffing. They were also brought in as additional staff on a ward if there was an increase in clinical demand. In the six months leading to the inspection bank or agency staff were used on 252 occasions. Additional staff were required on a further 32 shifts but these could not be filled by bank or agency staff.

There were three whole time equivalent consultant psychiatrists who covered the services at both Prospect Place and Tatton Unit. Each consultant worked a number of sessions within the low-secure service each week. This meant there was always consultant psychiatry cover at the hospital sites and out of hours arrangements in place. There were 1.3 whole time equivalent clinical psychologists in post.

In addition to the nursing staff each of the wards received input from occupational therapy and technical instructor staff and there was an activity worker providing input into each ward. These combined were a team of eight whole time equivalents. There was a social worker in post full time at Prospect Place and a full time social work vacancy at Tatton Unit.

The sickness levels of staff based at Prospect Place in the 12 months prior to the inspection was 6.7% and 10.6% at Tatton Unit. These were higher than the average sickness rates within the national health service of 4.4% as

published at March 2015. The trust was in the process of recruiting into the vacant posts which at the time of inspection were 11.7% at Prospect Place and 22% at Tatton Unit.

The wards required two qualified and three unqualified nurses on each shift. Nurses worked 12 hour shifts 07:30 to 19:45 and 19:30 to 07:45. At night, each ward had one qualified nurse and two unqualified staff. Details of how many staff should be on duty were displayed at the entrance to each ward. Charge nurses, occupational therapy, and activity staff were on duty in addition to those core numbers. Bank and agency staff were required to sign confirmation that they had received a local induction prior to working on the ward unchaperoned.

We reviewed the documents that were completed at every shift change. There were effective handover meetings taking place on each ward. Handover records were made ensuring important information about patients was handed over to new staff coming on duty. The handover sheets were available for review by staff. If staff had been on holiday they could quickly appraise themselves of key information.

There were wall mounted white boards in each of the nursing offices. These held key information about each patient on that ward. There were tasks allocated to each staff member on duty. These included a lead nurse for security that shift. These helped the nurse in charge allocate work within the staff team each shift. The social inclusion and recovery ward at Prospect Place had introduced the Safewards model of working. It was the trust intention to roll it out on to the other wards within the low secure services. The Safewards model supports staff and patients to review some of the factors that may be contributing to incidents of violence, self-harm and patients absconding. It provides a model that encourages the implementation of ten interventions to help minimise conflict and maximise safety and recovery on inpatient wards.

Although the number of vacant posts for qualified nurses was not higher than elsewhere, members of the multidisciplinary team at Prospect Place staff told us that qualified nurse vacancies were causing pressures within the staff team and as a result there was a higher use of bank and agency nurses. Sometimes experienced staff were moved from their own wards to ensure more

Are services safe?

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

experienced nurses were working in the areas with greater clinical need. Unit managers and charge nurses told us they were able to bring in additional staff whenever it was required.

A GP attended both units twice a week and provided ongoing physical health care and follow up. There was a psychiatrist on call. In an emergency staff had access to emergency equipment that was available as a 'grab bag'. Staff would request emergency response via 999 if required. Staff on all the wards knew where emergency grab bags and ligature cutters were located. These were checked on a daily basis so that all staff knew the equipment kept within the grab bag was in full working order.

There were six consultant psychiatrists across the rehabilitation and high support directorate. Each provided input on a sessional basis on to the low secure services. This meant there was always consultant psychiatrist availability on each unit. Out of hours cover was provided via an on call rota. The four consultant psychiatrists working at Prospect Place had patients under their care on each of the wards. Each of the four consultants had patients in the 13-bed assessment ward.

The trust provided the following mandatory training figures that the ward staff had completed by end April 2016. The trust target for all training was 95% completion. The exception to this was intermediate life support where the trust target was 60%.

The average rate of completion of mandatory training across low secure wards was 93% with Tatton achieving 98%.

Previous quarter reports indicated an improved percentage completion of mandatory training at Prospect Place. Staff had become out of date for the required refresher training or was new starters who had not yet completed required training. Charge nurses confirmed that plans were in place to prioritise staff attendance at all required training.

Assessing and managing risk to patients and staff

Staff told us that the ethos of the trust was to focus upon least restrictive practice. This was confirmed by four patients who told us it was the least restrictive environment they had been admitted to. Restrictive practice was discussed in handovers, individual supervision and at individual clinical review meetings. However, at Tatton Unit there was restricted access to outdoor areas. Although

extra access was given to the outdoors if it was exceptionally warm, generally there were seven facilitated outdoor breaks of 15 minutes each day. Staff could not explain why there was restricted outdoor access at Tatton Unit but not at Prospect Place.

For the three months to end March 2016 there were five episodes of seclusion. These all related to Prospect place. The longest duration of this was 19 hours. There were nine incidents of restraint in the same time period. Five of these restraints resulted in an episode of seclusion. Eight restraint incidents were recorded as standing and one episode of restraint in a seated position.

We were given examples of blanket restrictions that had been changed to less restrictive choices. An example was a daily community meeting that all patients had been expected to attend was now run as a breakfast club that patients could choose to attend if they wished.

There was an airlock into both Prospect Place and the Tatton Unit. At Prospect Place there was a room within the air lock where patient searches could be undertaken whilst maintaining privacy and dignity. Searches were not undertaken routinely and were based upon risk concerns.

Staff described attempts would always be made to help to de-escalate any incidents of agitation, anger or distress. Staff were trained in both preventing and management of violence and aggression or breakaway training, dependent upon their role. All inpatient nursing staff attended a five-day course with annual refresher.

Domestic staff were briefed at the start of every shift and informed of any risks or concerns that may affect them during the course of their work. These included infection prevention risks to enable domestic staff to ensure appropriate actions. There were effective infection prevention measures in place on all the wards and regular audits undertaken.

All staff we spoke with stated they had not been involved in the administration of injected rapid tranquilisation for many months. Where additional prescribed medication was administered, staff could describe the additional physical health observations that would be undertaken.

Staff told us that the seclusion facility at Tatton Unit had never been used. During the inspection we reviewed the

Are services safe?

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

paperwork relating to the most recent episode of seclusion at Prospect Place. The paperwork complied with the Mental Health Act Code of Practice and the policy in place at the trust.

At March 2016 100% of inpatient staff at the Tatton Unit and Prospect Place had received mandatory adult safeguarding training. During the same period 96% of staff had received child safeguarding training. The social worker based at Prospect Place provided support advice and guidance about safeguarding. They were available to offer advice to staff at the Tatton Unit until the post was filled. The unit managers were the leads for safeguarding. Flow charts were on the office walls reminding staff how to follow appropriate safeguarding processes.

Ward based staff gave us good examples of safeguarding actions that had been taken. This demonstrated that staff were aware of the procedures to follow. The examples given were complex and appropriate actions were taken to safeguard patients and others.

We reviewed the medication management arrangements at both units. We reviewed 12 prescription charts and associated clinical records in detail. The prescription charts were up-to-date and clearly presented to show the treatment people had received. The ward pharmacist alerted the multidisciplinary team if there were any issues relating to the prescribing or administration of medications. We saw where that occurred action was quickly taken to rectify the issue. Personal files showed that regular competency in administering medication assessments were being undertaken.

The ward pharmacist regularly attended the clinical review meetings and provided prescribing information and advice. They would also meet with patients on a one to one basis to discuss any concerns or queries relating to medications. Patients were supported to self-administer their own medication. Risk assessments were completed and nurses monitored safe self-administration. Appropriate arrangements were in place for supplying patients with leave and discharge medicines. The trust had signed up to the 'Choices and Medication' website and if requested this was used to provide written information to patients. This ensured that medications requiring refrigeration were being stored safely.

Track record on safety

From January to March 2016 there were a total of 81 recorded incidents within the low secure inpatient wards. Of these 37 occurred within the assessment ward at Prospect Place. Incidents were rated in severity as no injury damage in 34 incidents, 26 minor incidents and 21 significant incidents. The majority of significant incidents related to violence and aggression. We saw how the low-secure services shared that incidents had occurred within their own teams.

Reporting incidents and learning from when things go wrong

Staff had a good understanding of the types of incidents that required reporting. They felt competent in using the trust system to do so. Managers compiled key themes reports. These gave detail of the previous months types of incidents being recorded within the service. Charge nurses cascaded this information to their own teams through regular team meetings. More serious incidents would be subject to a detailed review and a preliminary report compiled. Senior clinical staff would undertake these reviews.

Senior managers attended a monthly governance meeting where incidents from across the trust were reviewed, including coroner reports. Pharmacy staff would also present detail of medication errors and any prevented errors. Feedback was then shared at the directorate team meetings. Unit managers and charge nurses would cascade the detail through ward based staff handovers and individually in supervision. Managers would also send emails to staff to draw their attention to changes, updates, and learning from incidents.

Prospect Place had a number of incidents of failure to return from unescorted leave. The management team worked jointly with the Tameside police liaison officer for the area to review and discuss management plans and agree protocols.

The trust provided online training about the duty of candour. Managers were monitoring compliance with this training. At the time of this inspection 77% of the required staff had completed it. Staff had some knowledge of the requirements relating to duty of candour. They had knowledge of the types of incidents, events, or near misses that should be reported. They knew how to record

Are services safe?

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

incidents on the trust risk system. They were all aware of the requirements to explain, and where appropriate, apologise to patients. Staff were not aware of any incidents that had occurred that met the threshold.

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

The clinical pathway team completed risk assessments before the patient was admitted. This meant ward staff were aware of historical and current risk issues and events. These were reviewed and updated within the first month of admission. Each patient had a named nurse. Their role was to ensure assessments were completed, care plans developed and regular reviews occurred. Named nurses spent one to one time with patients and worked with the patient to develop their shared pathway document, care plan and to develop risk management plans. Staff rotas tried to ensure named nurses were on duty and able to attend their patient's clinical reviews.

We reviewed 12 clinical care records. The care plans and risk assessments were up to date and signed by the patient where required. Care plans were detailed and personalised to the individual. It was not always clear that patients had been fully involved in developing their own care plans. This was shown in the way areas of need and planned interventions to meet those needs were worded. Staff described that care plans were developed around any restrictions for leave. All clinical records we reviewed had an up to date trust approved risk assessment (TARA) in place. These included a risk formulation and a risk management plan.

Physical health care within care plans was good. There were completed physical health assessments and physical health reviews for all patients. These included health screens, such as cardio metabolic, and vaccinations. Staff recorded in the clinical records when a patient declined a physical health examination. We saw plans to revisit the decision and encourage the patient to reconsider. Specific health issues including tissue viability, obesity and other weight issues, dentist, optician and chiropody needs were being considered during assessments. Outcomes from requested physical health tests were discussed as a standard agenda item at the clinical reviews. These included blood and urinalysis results, and feedback from dental and podiatry appointments.

Best practice in treatment and care

There were two paper clinical records for each patient. One contained the doctor's contemporaneous notes and the other was a multidisciplinary record completed by nursing,

occupational therapy, and psychological therapy staff. An electronic summary of the multidisciplinary and medical clinical records was displayed during the clinical review meeting.

Dependent upon individual patients' needs there were historical clinical risk (HCR-20) assessments and sexual violence risk (SVR-20) completed. These were in addition to the trust risk tool. Some patients had a risk of sexual violence protocol completed. These contributed to an individualised formulation focusing on risk issues. There were prompt sheets guiding staff to consider all areas of risk and to document these in the clinical notes. A 10-point risk assessment document was completed for every episode of leave from the wards in the low secure service.

Ward based staff gave a good account of the evidence base for the interventions they provided. These were in line with recommendations in a range of National Institute for Health and Care Excellence guidelines. These included psychosocial interventions to help patients manage distressing symptoms and management of violence and aggression. A dual diagnosis nurse provided motivational interviewing and structured relapse prevention sessions for patients with a significant substance misuse history.

Occupational therapy staff used the model of human occupation, rehabilitation, leisure, vocational and recreational activities. Specific interventions aimed to address development of self-esteem, confidence, sense of purpose, and role identity. As well as focusing upon symptom recovery, the interventions also addressed vocational and education needs. There were links with training and development services in Rochdale who provided construction training in the local community.

There was a stepped care model for accessing psychological interventions. This meant ward based staff such as nurses, health care assistants and some medical staff provided psychologically informed interventions. A number of staff across the two units had additional training in cognitive behavioural techniques. Clinical psychology staff provided a range of psychological interventions including cognitive analytic therapy work aimed at preventing future offending, symptom management, dialectical behaviour therapy, motivational interviewing, psychological wellbeing group work, neuro assessment,

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.

and follow up interventions. Patients accessed programmes and group work at other trusts such as a specialist offender programme. This was part of the North West Recovery and Outcomes meetings for secure services.

Nurses told us that the support provided by the ward pharmacist was very good. The ward pharmacist was routinely part of the weekly ward round to provide prescribing information and advice. The trust had signed up to the 'Choices and Medication' website and if requested this was used to provide written information to patients. The pharmacist met with patients to discuss their medication on request. Patients were supported to self-administer their own medication. Risk assessments were completed and nurses' monitored safe self-administration. Appropriate arrangements were in place for supplying patients with leave and discharge medicines.

A GP visited the units twice a week to look after patients' physical health conditions. There was also a nurse physical health lead, who carried out physical health care monitoring. There was access to trained smoking cessation champions but this was not a smoke free site so uptake was variable.

We saw that a report was shared at the six weekly performance review report to confirm compliance with provision of a minimum 25 hour structured activity per patient per week. This included explanations of when there were problems in providing this due to staffing issues.

Skilled staff to deliver care

We reviewed the nurse and health care assistant staffing levels for the six-week period prior to the inspection. We saw that additional staff were requested when clinical need increased. In addition to the staff on the nursing rota each ward had an activity coordinator and input from an occupational therapist and technical instructor. There was good access to medical support during core hours and at evenings and weekends. Charge nurses were supernumerary and not included in the staffing rotas.

At the time of inspection, there was one full time clinical psychologist providing input to the three wards at Prospect Place. At the Tatton Unit there was 0.3 of a clinical psychologist. Prospect Place had a dual diagnosis worker in the team to support the specialist drug and alcohol work that the teams were providing. Both the Tatton Unit and Prospect Place had a full time social worker based on site. Pharmacists visited the wards regularly.

Staff described the induction they received when first going to work on the wards. They said this adequately prepared them for working within the low secure environment. We saw completed induction packs in each of the personal files that we reviewed. There were induction checklists for bank and agency staff who may be attending to work on a ward they had been to previously.

All staff had received an annual appraisal. Those that had not were on long-term sick leave or had been working for the trust less than three months. The annual appraisals were well structured and detailed the trust's core objectives and linked these to each individual's personal objectives. Staff received line management supervision in line with the trust policy. Managers used a supervision checklist to ensure staff were receiving regular supervision in line with the policy.

Line management supervision incorporated clinical supervision. However, staff had access to a range of clinical supervision on an individual or group basis. The psychologist at Prospect Place received additional clinical supervision from the psychologist based at the Tatton Unit. The dual diagnosis nurse received clinical supervision from the psychologist. The social worker described receiving line management supervision and aiming to secure clinical supervision from an independent social worker.

Staff had access to their electronic staff record and were able to monitor their own compliance with training. They could also access online training both mandatory or as part of their own additional ongoing learning. There were good systems in place to support charge nurses and managers to ensure all their staff remained up to date and supervised. Each ward held a regular team meeting.

Charge nurses and unit managers had a good knowledge of human resources policies. These included capability in work policies. Managers gave us examples of when and how they addressed poor performance within their teams. We saw in personal files where policy had been followed and action taken. Staff told us that when they raised concerns as a dignity at work issue they were well supported and action was taken.

Multi-disciplinary and inter-agency team work

There were weekly multidisciplinary team meetings on each ward. There was good representation from nurses, medical staff, psychology, and occupational therapy and pharmacy staff. Community mental health staff, who would

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.

be involved when patients were discharged at some future point, were invited and attended regularly. The independent mental health advocates were present at the meetings we attended. They shared feedback on behalf of the patient.

Documentation was prepared prior to the meeting. This included a precis of the information contained within both clinical record sets. There was also a document completed by the patient and his named nurse. This provided feedback from the patient's perspective when they were not present for those discussions. At the meetings we attended, the patients had indicated which parts of the meeting they wished to attend.

Although no 'handovers' between staff on different shifts took place during our time on site, we were able to review the handover documents on each ward. We saw that comprehensive detail was shared at these meetings. We spoke with a range of different staff disciplines. Each informed us that team working was good and communication was effective. External professionals including a commissioner and an independent mental health advocate confirmed this.

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

We found that all required Mental Health Act documentation was in place within clinical records. There were good quality risk assessments and evidence of additional ones undertaken prior to patients taking leave from the wards. Staff spent time with patients after they got back from leave to discuss how it had gone. Staff were regularly discussing individual patients' rights with them and documenting that this had occurred. Patients had their individual wishes and aspirations recorded within the 'my shared pathway' documents. These were being completed for all patients.

The Mental Health Act administrator oversaw systems that provided prompts and reminders to clinical staff to ensure all responsibilities under the Act were completed. There

were independent mental health advocates who attended Tatton Unit and Prospect Place. Their role and support were established. They were positive about the support and involvement they were given from the inpatient staff.

The seclusion facility at Prospect Place was in use during our visit and it was therefore not possible to review the premises. The paperwork for the episode of seclusion in process met trust policy and complied with expectations within Code of Practice. No central log of previous seclusion episodes was available for review however and we were told these were located within individual patient's clinical record. The seclusion suite at the Tatton Unit complied with the Mental Health Act requirements

Some nursing staff told us they had not been able to access Mental Health Act training in the previous 12 months. Despite this staff had a good knowledge of the Act, including the Code of Practice.

Good practice in applying the Mental Capacity Act

Nursing staff were able to detail the core principles of the Mental Capacity Act, in particular that all patients are assumed to have capacity unless otherwise assessed. They also had knowledge of best interest decisions and acting in the least restrictive way.

Within the low secure wards 77% of qualified staff had completed Mental Capacity Act training to date. There were plans for the remainder of the staff to complete the required training. A total of 11 qualified nurses had recently completed a train the trainer course and were in the process of rolling out additional awareness training for health care assistants within the service.

Medical staff carried out an assessment of a patient's capacity to consent on admission. This was periodically reviewed during the clinical review. Psychology staff and the unit-based social worker assisted in best interest decision making and best interest meetings.

No patients had been detained subject to Deprivation of Liberty Safeguards. There was a policy staff could access for advice and guidance if required.

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

We spoke with 11 patients from both units in small groups or individually. They told us that the ward staff were good and that generally they worked hard to assist them. Patients said there were usually adequate numbers of staff although it could be frustrating if leave was cancelled at short notice if there were problems.

We observed staff during our visits. These included in meetings and when they were interacting directly with patients. We listened to how staff referred to patients in meetings and in clinical discussions. We saw that staff were professional and courteous. We observed that staff had good knowledge of the patients and the interactions and contacts were respectful and dignified.

The involvement of people in the care that they receive

Each of the wards held a weekday community meeting. This was chaired by a staff member and well attended. The meetings followed a structured agenda and minutes were taken. Each week the meeting reviewed the actions agreed at the previous meeting. This demonstrated that actions were being taken when issues were raised by patients.

Patients told us they were confident that they were receiving the right care and treatment. They felt their opinions and views were considered and that they were listened to. Patients had access to their named nurses to have one to one discussions. This included for their physical health problems. Patients felt involved in their care and able to express their views. They said they were listened to at their monthly clinical review meetings. Patients told us they had been fully informed of what to

expect during the process of their admission. The process had made them feel staff understand their views were important. This was not the view of all patients however. During the visits, we escalated complaints that were made. We asked the senior managers to look into, and respond to, the patients wishing to complain.

At the most recent friends and family survey in March 2016 67% of respondents were likely or highly likely to recommend the forensic low secure service. The trust has implemented triangle of care across adult acute services and are intending to roll this later this year within secure services. This is a national initiative led by the carers trust. The focus is upon patients, carers and professionals working together to improve services and influence patient safety. Ward staff advised there were significantly lower numbers of carers and family members that undertake visits to the low secure services in comparison to visits on other types of mental health units. The low secure services were involved in the work of North West Recovery and Outcomes meetings. This peer support group across other north west secure providers looks at ongoing service developments and includes looking at improving support for carers. The North West network is one of nine recovery and outcomes groups. Each is focused upon the continued developments of their local services.

Tatton Unit were piloting patient completed feedback forms. These enabled patients to rate their experience and preference for specific interventions. Forms were reviewed within the clinical team meetings and patients were fully involved in discussions.

Staff attended a North West Family and Carer event in March 2016.

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

The average bed occupancy from July 2015 to 31 December 2015 was 97% for Prospect Place and 95% for the Tatton Unit. There had been one readmission to Prospect Place within 90 days of discharge. This was due to the step down placement being unable to meet the patient's complex needs.

Discharge planning was a standard agenda item at clinical review meetings. Each patient had a clinical review at least monthly. The document that was prepared in advance of the clinical review included a section to record 'issues to be addressed prior to discharge'. There was also a section to complete 'barriers to discharge'. In the clinical review meetings we attended these had been completed. The needs that still required inpatient care to meet were reflected within the patient's care plan. The social workers based within Prospect Place and the Tatton Unit provided support to the existing community care coordinator. This was to assist in identifying needs so appropriate support could be in place at discharge and in making applications to appropriate providers and funding panels.

At Prospect Place four rooms were separated from the remainder of the ward. In addition to their own room and ensuite facility the patients in those rooms shared a communal lounge, dining and kitchen area. These more independent rooms were for patients moving toward discharge. Patients were undertaking a structured rehabilitation programme aimed at further developing independent living skills. Patients tended to remain in these flats for a number of months. They were discharged to their on-going placement as the rehabilitation programme was completed.

In March 2016 the average length of stay for patients that were on the wards at Prospect Place was 707 days and at Tatton Unit 744 days. The trust also provided detail of the average length of the hospital stay for patients who had been discharged in the previous three months. This showed that the average length of stay at discharge from Prospect Place was 927 days and 1016 days at Tatton Unit.

In the six months prior to this inspection there had been one delayed discharge on the Tatton Unit and one delayed discharge at Prospect Place. Both of these instances were due to difficulties identifying an appropriate discharge

placement. Both had subsequently been discharged prior to this inspection. All elements of care pathways, including referral data, progress, and discharge plans were discussed at six-weekly performance meetings. These were attended by specialist secure commissioners.

The facilities promote recovery, comfort, dignity and confidentiality

Each of the wards was bright and airy. Each ward had a lounge and another quiet lounge area. Bedrooms were pleasant and spacious with ensuite facilities and adequate storage. There were secure areas to store personal belongings and all patients had a key to their own room. There were observation panels in the bedroom doors and patients could close the integral blind on these if they wished. All patients had their own televisions and many had a games console and could play music in their own rooms. Patients could have their own mobile phones. There were pay phones on each of the wards however the phone on the assessment ward at Prospect Place was broken and had been for two weeks. Staff said an office phone would be made available if someone wished to make a call. Most patients had their own mobile phones they could make calls from.

The majority of patients were dissatisfied with the food. In particular, they were unhappy about the menus, which they said were repeated so regularly there was very little actual choice. We observed lunch being served on two of the wards we visited. On both only four patients attended. Different cultural needs and dietary requirements were available where required. We saw that concerns regarding food were mentioned in meetings on each of the wards. A food audit was carried out on Tatton ward in May 2016. This was looking at the quality of the food provided. The overall score was 78%. A food audit was carried out at Prospect Place in January 2016. The overall score was 69%. We saw that the catering manager responsible for the provision of food to the low secure services had attended a number of ward based community meetings, as had the modern matron. There was agreement to address a number of issues that the patients had raised. These actions were in progress at the time of inspection.

We saw that patients had access to a range of drinks and snacks, including fresh fruit. Meal times were displayed and prompts given to encourage patients to attend for their meal. There were facilities for patients to store their own

Are services responsive to people's needs?

Good 

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

food. Each of the patients could engage in cooking and menu planning on the wards and there were weekly take away evenings. We saw posters and information leaflets promoting healthy eating and other lifestyle advice.

Each of the wards had a gymnasium for patients to use. There were pool and table tennis tables. There was access to a rehabilitation kitchen where groups or individuals could have access to make meals. There were communal lounge areas and quiet spaces. There were dining areas incorporated in to the lounges. Each ward provided facility to make hot drinks up until midnight and cold drinks whenever patients wished.

The outdoor space at the Tatton Unit was attractive with sheltered seating areas, flowers, and shrubs. The outdoor space at Prospect Place was bare of any decoration or flowers. The outdoor space was large. One ward had access to a basketball hoop with ample space to enable play. The garden areas were secure. There was a visiting room located outside of the ward at both of the units. Staff assured us that it was rare for family or carers to have a delay in accessing a booking for the visitors' room. There were interview rooms and activity rooms on each of the wards. There were clinic rooms with examination couches and equipment to enable routine physical health observations to be undertaken.

Meeting the needs of all people who use the service

Bedrooms were en suite with showers. There was access to baths at request. Each ward had access to an adapted bathroom to meet the needs of patients who may have restricted mobility or use wheelchairs. Both the units were at ground floor level with no requirements to use stairs to access any upstairs areas on the ward, for activity areas or meeting rooms.

There were multiple noticeboards and leaflets throughout the wards. These displayed a range of information. These included details of activities and groups at the unit and within the local community, information relating to care pathways, understanding of individual rights and physical health promotion. There was information about how to complain, and how to access independent support and advice. Staff had access to the information leaflets and

welcome packs via the intranet. They could print duplicates off in a range of different languages if it was required. There were signs on the office walls reminding staff how to access interpreters when they may be required.

Occupational therapists and technical instructors provided input on each of the wards. They provided individual and group work. Each ward had input from an activity coordinator who provided support to patients who did not have leave. These activities included access to computers, cooking sessions, health promotion groups and board games. We saw evidence of these during our visits. Patients had individual timetables. Activities were provided seven days a week, some of which were in the evenings. Ward based staff facilitated outings at weekends using the unit transport. The types of activities to undertake were agreed at the weekly patient meetings. There were organised football groups, attendance at gyms in the local community, and an organised music project.

Prospect Place had access to a multi-faith trolley. This could be moved across the unit dependent upon where it was required. It could be taken to a private room for use. Staff were able to contact a range of local religious leaders who would visit the patient at the unit as requested. Some patients were supported by staff to attend for a religious service within the local community. There was access to a choice of food to meet dietary requirements of religious or ethnic groups.

The trust was working on the development of a recovery college, due to open in the summer. Two patients from Prospect Place were involved in the co-production of courses. The patients were due to shadow peer trainers at a neighbouring trust's recovery college. This was to develop skills in co-facilitating courses when the college opened.

Listening to and learning from concerns and complaints

Prospect Place had received one complaint in the six months leading up to this inspection. This was made by the community group at the social inclusion ward and was in the process of being investigated at the time of the inspection. There had been one complaint at the Tatton Unit in the same period and this had been resolved at the informal stage. There were posters and information leaflets across the wards visited. Each ward had a confidential comments box where patients could post their views or questions.

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

Pennine Care NHS Foundation Trust outlined the following vision across its services:

- to deliver the best possible care to patients, people and families in our local communities by working effectively with partners, to help people to live well.

The trust outlined the following strategic goals:

- to put local people and communities first
- strive for excellence
- use resources wisely
- be the partner of choice
- be a great place to work

The trust had also developed 10 principles of care. These defined the trust's expectations of the core values and behaviours of its staff and partner organisations. The trust goals and principles were incorporated into the annual appraisal documentation. Personal objectives were mapped against these. Staff had a good knowledge of the trust vision. Band 6 and above staff were aware of the trust's strategic plan.

Throughout the wards, in both staff and patient areas, we saw displays of the NHS England 6 Cs: care, compassion, competence, communication, courage and commitment. These reminders to incorporate compassion and care into all areas of nursing practice were defined by NHS England in 2012. There were posters and information about recent amendments to 'see think, act' the guidance produced by the Department of Health in 2010. This guidance supports staff delivering mental health care and treatment within a secure inpatient setting. It supports staff to provide relational security that is compassionate and patient centred.

Patients told us they reviewed the 'you said we did' posters. They told us this was how they could see that the things that they were raising and asking to be changed were being dealt with. We saw these posters throughout our visits to the wards. They were also noted at community meetings.

Nursing staff described good quality support from the charge nurses. Unit managers had an office based on the wards. Staff described them as being available and

accessible. Managers were knowledgeable about the patients and their needs on the wards. Staff said more senior managers were less visible but there were occasional visits by them to the units. There were regular communications from the senior executive team

Good governance

At both units there was a high compliance rate with annual appraisal. Appraisals were linked to the strategic plan of the trust. Staff confirmed they were encouraged and supported to undertake training. This included mandatory and other training aimed at further developing skills and expertise. Staff told us that mandatory training was treated as a priority and they were given time to undertake required online training and to attend classroom based training. Staff had access to coaching and mentorship and said that managers were supportive of their ongoing development.

All staff received regular line management supervision. Over a 12 month period regular supervision had not occurred on every ward. However, the staffing pressures the managers said had contributed to this had been addressed. We saw that more recently regular supervision was re-instated. Clinical supervision was incorporated within line management. Staff were encouraged to gain additional clinical support through group, peer and individual meetings.

Each ward had the right number of staff on duty each shift, although some of these were made up by the use of bank and agency staff. Bank and agency staff were mainly being used to cover the gaps caused by the nurses who had left their posts. We were told that a recent review at Prospect Place had resulted in the three wards being changed from each being 15 beds to a reduced number on the admission ward and an additional bed being created on the other two wards. At the same time staffing had been reviewed and a qualified and health care assistant post moved from the social inclusion ward to the assessment ward. At the time of the inspection this appeared to be an appropriate move of resources. Managers advised they would be reviewing the situation over the next few weeks to ensure the staffing establishment remained correct.

Staff participated in a range of audit activity. The majority of this was arranged centrally via the trust audit department and cascaded across the wards. There were local audit arrangements in place. These supported the managers and clinical leaders to monitor and ensure that required minimum standards were in place. These

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.

included audits of care plan completion, risk assessment quality, Mental Health Act requirements and medication management. We saw that staff undertook audits within their own teams and wards. These were in specific areas and the outcomes and recommendations shared within the teams. Examples included an audit of satisfaction with group clinical supervision sessions and the recommendations that these continue.

Both the units were involved in the quality network for forensic mental health services. This network is established nationally and members work together to provide expertise on areas of best practice and continued development. Both units participated in the annual peer reviews undertaken alongside other low and medium secure services.

At clinical review meetings, a record was made of all incidents that had occurred since the patient's previous review one month before. These were detailed on the electronic report. Incidents were discussed and reviewed by the multi-disciplinary team. Staff were clear what types of events or issues required recording on the risk incident system and knew how to do so.

We saw incidents were discussed at team meetings, unit manager meetings, and governance meetings across the low secure services. The trust provided a key themes report on a monthly basis and this was cascaded through the monthly senior manager meetings to the low secure service governance meetings.

We saw the trust shared lessons learned where incidents had occurred and staff retained the knowledge of changes that would need to be made. Managers followed up any changes required when they met for line management supervision.

Ward staff had been trained in adult and child safeguarding and understood the processes and procedures. Both units had an inpatient social worker who provided additional expertise and support following any safeguarding concerns.

All elements of care pathways, including referral data, progress, and discharge plans were monitored as key performance indicators for the service. Progress was reviewed at six-weekly performance meetings. There were attended by specialist secure commissioners. The secure

commissioners provided an additional link between the trust and other forensic mental health service providers. This further supported the pathways at admissions and discharge.

Charge nurses told us they felt well supported and they were given appropriate authority to manage their ward. Unit manager and clinical leads were able to submit items to be included on the risk register for the service. However, neither service had anything on the risk register.

Leadership, morale and staff engagement

All staff talked of the positive and supportive relationships they had within their own teams and their immediate managers. Staff were clearly highly motivated in their work and committed to the continued developments and success of the service. At Prospect Place however staff told us they were feeling under pressure due to how acutely unwell a high number of the patients were.

Staff talked openly about the loss of nursing staff from Prospect Place. They expressed concern about the impact upon the remaining staff. In particular, they described the pressures on the unit caused by an increase in patients' disruptive behaviours due to using psychoactive substances, known as 'legal highs'. They described that the unit was losing experienced nurses. Although there were actions in place to recruit into the vacancies left managers were not completing exit interviews with staff who were leaving the trust. These would have enabled managers to consider other support arrangements or changes that could have been implemented to support the staff.

Prospect Place nursing staff told us that access to street drugs was problematic and despite prohibition of psychoactive and other illicit substances, and search procedures, drugs were still managing to get into the wards. Consequently drugs were having a detrimental effect upon the behaviours of a number of the inpatients. We were told this was affecting morale. Six Prospect Place staff told us that morale was low. They told us that staff believed nurses had left due to the pressure of managing challenging behaviours and feeling that they were not well supported. We checked with managers if these issues were raised in exit interviews. However they had not held them with the staff who had left. It appeared the managers had not looked in to the staff concerns. Different disciplines within the teams told us they felt listened to and valued within the multi-disciplinary teams.

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.

The staff we spoke with during this inspection told us they felt listened to and supported by their managers and that generally the teams were supportive of each other. They told us the vacancies had increased pressure upon the remaining staff and this in itself was stressful. Staff told us they were encouraged to raise concerns and express their opinions and could do so without fear of recrimination. Staff told us there was no evidence of bullying. They confirmed they knew how to blow the whistle if they felt this was required. Staff said there were opportunities to undertake assertiveness training and a range of leadership training. Staff understood the core principles of duty of candour. They were clear about the need to notify patients and explain and apologise to patients and their families in the event an incident or near miss occurred.

Staff said they had opportunity to feedback on services and had input into service development through regular supervision and annual appraisal. Staff from each discipline provided representation on a range of trust wide groups looking at service improvement.

Commitment to quality improvement and innovation

The provider participates in the quality network for forensic mental health services, a nationally recognised accreditation scheme. The most recent reviews were

undertaken on Tatton Unit and Prospect Place in October 2015. At that time Tatton Unit fully met 83% of low secure standards, meeting 100% of criteria in six of the eleven standard areas. Prospect Place fully met 85% of low secure standards. There were recommendations for both services, which have been incorporated into their action plans.

Senior managers held an annual integrated quality matrix review of each inpatient area. Each ward received a one day visit by a team including clinical staff, support staff and patient advice and liaison service. The team look to evidence whether standards under 10 domains have been met. We saw that Tatton Place had been rated green in all domains. This meant the ward scored the highest possible. It was the only ward on the matrix to do so. The achievement was to be recognised by senior managers.

We were told of a recent initiative co-produced with patients. An event 'on the road to recovery' was held in December 2015. This had contributions from all of the wards across the rehabilitation and high support directorate. Each ward produced a visual display board detailing what recovery meant to individual patients. These were displayed during an event of music, poetry, personal stories and art work. Family, friends, commissioners, staff and patients were all invited to attend.