Coventry and Warwickshire Partnership NHS Trust

Forensic inpatient or secure wards

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Forensic inpatient or secure wards

Inadequate 

We carried out this unannounced focused inspection because we had concerns about the quality of services.

The service

Brooklands hospital is a specialised hospital site which provides inpatient care and treatment to adults and children with a learning disability or autism. The hospital is part of the learning disability and autism services delivered by Coventry and Warwickshire Partnership NHS Trust. There are 4 forensic inpatient wards based at Brooklands Hospital.

The forensic inpatient service is made up of:

- The Janet Shaw Clinic, a medium secure unit for adult men,
- Eden ward, a low secure ward for adult women,
- Malvern ward, a low secure ward for adult men, and
- Rainbow ward, a low secure ward consisting of 3 individual apartments for men with a diagnosis of autism.

During our inspection, we visited Janet Shaw, Eden, Malvern and Rainbow.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, Right care, Right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

What we found

At an inspection in March 2022 the service was rated inadequate overall and following that inspection we served 6 requirement notices for breaches in regulation.

At that time, we rated safe, responsive and well led as inadequate, and effective and caring as requires improvement.

As a result of this inspection on 28 March 2023 the overall rating of this service stayed the same. Due to the seriousness of our concerns following our site visits, we used our powers under Section 29A of the Health and Social Care Act 2008 to issue a warning notice to the trust. We use Section 29A warning notices with NHS Trusts when it appears that the quality of health care provided by the trust requires "significant improvement". The notice provided the trust with a deadline by which they were required to make significant improvement to the areas identified in the notice. Details of the notice can be found at the end of the report.

Running the service

- staff had the skills to develop detailed positive behaviour support plans and risk assessments,

Our findings

- care plans were individualised and met people's needs, people had a copy of their care plan and could attend their weekly ward review,
- people received a range of treatments in line with national guidance for best practice. These were delivered in group and individual sessions,
- vacant occupational therapy posts had been recruited to.

However,

- the service did not ensure there were enough staff within the service trained to deliver safe, person-centred care suitable for a secure environment,
- the service did not ensure the secure environment was fit for purpose and meeting the needs for people. Staff did not complete thorough environmental checklists to protect people from harm,
- staff did not have easy access to clinical information,
- blanket restrictions for the service were disproportionate to individual risk. People said they could only have a hot drink at certain times in the day. The patient information booklet on Rainbow stated people could only access leave once they had completed daily tasks and were looking clean, smart, and tidy. The provider told us they have reviewed their use of ward rules and this no longer applies.
- the service did not adhere to the Mental Health Act Code of Practice in relation to long term segregation and seclusion practice, including timeliness of reviews.

How we judged the service

We judged the service as inadequate overall. The service did not meet the principles of Right support, right care, right culture because:

- the service did not provide safe care,
- people did not have an individualised timetable and could not shape their own meaningful activities, independence, and quality of life. People said activities were often cancelled and did not happen on evenings or at weekends,
- people did not always have expected discharge dates and were delayed in their discharge from hospital, so were kept in hospital longer than necessary.

The provider had not ensured:

- staff were carrying out observations of people in accordance with their policy and the National Institute for Health and Care Excellence (NICE) guidance to protect people from harm,
- their quality improvement plan and audits of the service were effective in mitigating risk and improving quality for the people in their care,
- staff were receiving supervision in line with trust policy, staff nurses said they felt burnt out,
- people did not have access to contraband items, this led to subsequent incidents,
- staff were completing accurate records when people were secluded,
- people felt safe with bank and agency staff.

Our findings

Is the service safe?

Inadequate  

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

All wards were not always safe and fit for purpose. However, they were clean, well equipped, well-furnished, and well maintained.

Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all ward areas and did not always remove or reduce any risks they identified.

Staff used an environmental security checklist 'app' to complete a daily environmental check, however the app was only working on Rainbow, and other units were completing a paper version. Managers said the app had technical issues and was being reviewed. We sampled a month of paper checklists and found gaps on most days. Janet Shaw and Malvern had gaps where risk items should have been checked twice a day, this was often only completed once. Staff did not always complete garden checks. Rainbow had gaps in the paper checklist, where only half or none was completed. Eden ward had gaps for weekend checks and a missing day. We found the same issues at the inspection in May 2022.

Environmental checks were not always thorough and there had been incidents of self-harm including ingesting risky items. Governance minutes for Janet Shaw January 2023 stated, "concerns raised around swallowing screws/batteries and has become unacceptable and [we] need to manage this risk". Weekly Multi-disciplinary team (MDT) minutes we reviewed highlighted the same concerns. However, only 8 incidents related to ingestion had been reported internally in 12 months. We were concerned not all incidents had been accurately recorded and did not reflect the level of risk on the unit. During a ward tour of Janet Shaw, we saw a screw and plastic wall plug left in the wall from a replaced TV cabinet. This was reported to staff at the time.

Governance minutes for Rainbow, Malvern and Eden reported concerns with contraband items on the units. Some people were searched on return from leave however this was not consistent. The secure steering group agreed in December 2022 people would be searched on return from leave and random room searches would take place twice weekly.

We took action following the inspection and told the trust they were required to make a significant improvement in this area.

Staff could observe people in all parts of the wards and there were mirrors in place to mitigate any blind spots. CCTV was installed in some communal and seclusion areas.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe.

Our findings

Staff had easy access to alarms and people had easy access to nurse call systems. Each staff member had an alarm and there were enough alarms on the ward for staff and visitors. A staff member on Janet Shaw said during an incident of staff assault agency staff had not activated their alarms quickly enough.

Maintenance, cleanliness, and infection control

Ward areas were clean, well-furnished, but were not always well maintained and fit for purpose.

The premises were clean, and staff kept cleaning records, but these were not always up to date.

Cleaners visited the wards every day. Wards were visibly clean, and furniture was in good condition and suitable for the unit. People on Janet Shaw said over the past year new furniture had been purchased and the unit had been painted. However, we found gaps in daily cleaning audits, 3 days out of a week were not signed for on Eden and weekends were not always signed for on Janet Shaw. We found issues with cleanliness at the inspection in May 2022.

Janet Shaw unit reported significant patient related damage over the past 6 months. Bedrooms had new anti-barricade doors. At the time of inspection 5 doors were reported as not working and were on the maintenance log for repair. Heavier doors had been fitted in the corridors, but these had caused some structural damage to door frames which had caused cracks in the plasterwork around the frames. Some doorframes had been replaced and this had caused gaps in the flooring which were covered with high visibility yellow floor tape.

Governance minutes for Rainbow in February 2023 reported a faulty secure airlock system to the entrance of the unit. An airlock is 2 doors which electronically interlock so both do not open at the same time. This had been reported to maintenance in May 2022 who said the airlock entrance would continue to break and needed investment to fix it permanently. This had been reported 14 times in just over a year.

Our inspection identified some concerns in regard to the security of the Janet Shaw Clinic medium secure unit environment and was reflected in the trust's local risk register in August 2022. The concerns have been communicated to the Trust for the purpose of taking action

We took action following the inspection and told the trust they were required to make significant improvement in this area.

Staff followed infection control policy, including handwashing. Staff were bare below the elbow and were aware of the current guidance on wearing personal protective equipment (PPE). PPE and hand sanitiser was available at the entrance to each ward.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication.

There was a toilet, but it did not have a clock. Staff said clocks had been removed from all seclusion rooms following an incident. Clocks were displayed in the window of the seclusion suite so they could be seen by the person.

In October 2022 we were informed Janet Shaw's seclusion room needed repair and had been out of use for 3 months. People who required seclusion were transferred via secure transport to another ward. The trust developed a 'Safe transfer of a person between seclusion services' model to support staff in moving people safely, with privacy and dignity. A 'crash' team was on site for extra support during these waits for secure transport. Staff said this felt unsafe for people and staff. At the time of inspection, the seclusion area was back in working order.

Our findings

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic rooms were clean, tidy, and well maintained. Staff cleaned clinic rooms daily and kept up to date records to confirm this had taken place. Ward managers carried out a monthly audit.

Staff checked, maintained, and cleaned equipment. Staff recorded the date that equipment was checked and when the next check was required.

Safe staffing

The service did not have enough nursing who knew the people and received basic training to keep people safe from avoidable harm. The service did have enough medical staff.

Nursing staff

The service did not have enough nursing and support staff to keep people safe.

Staffing was on the trust's risk register due to its impact on safety and quality of care. Permanent nurses said they felt burnt out. Some people said they didn't always feel safe with bank and agency staff, they didn't always speak to them and take part in activities.

There was a high use of bank and agency staff which had significantly increased since our last inspection. Managers had requested 562 shifts in February 2023 to be filled by bank or agency staff, 587 in January 2023 and 537 in December 2022. There was a high number of unfilled shifts. In February 2023, 96 shifts were unfilled (16%), 68 were unfilled in January 2023 (11%), and 103 were unfilled in December 2022 (19%). Bank and agency staff ran night shifts on Rainbow, according to governance minutes. Commissioners of the service reported occasions when one registered nurse had covered 2 of the smaller units on site. The clinical lead confirmed this happened when the site did not have enough qualified nurses on shift for each ward to have a dedicated nurse.

There were not enough staff to safely manage enhanced observations. On Janet Shaw there was not enough staff at the start of the shift to cover the number of enhanced observations and observation levels were altered. We observed a reduction in people's enhanced observation level without MDT consultation, based on staffing numbers and not in line with policy. The consultant had been present in the morning handover and a reduction in observations was not discussed. Although the trust had updated its policy on adjusting observations there was no approval date or ratification date for this occurrence.

Senior management team led a daily safety huddle across the site to discuss safe staffing numbers on each ward. Wards did not feedback heir acuity and ckinical risks that would impact safe stafing levels, and not all wards attended.For example, a person had been unwell overnight and an urgent hospital visit was being considered. Thiscould have an impact on staffing numbers during the day, but this information wasn't fed into the huddle.

The service had a high vacancy rate. Vacancies for band 5 qualified nurses were high across the service, with only 5.53 full-time equivalent nurses recruited out of 18 full-time equivalent posts. This was a vacancy rate of 69%. The service had 19.89 full time vacancies within the service, this had improved from 24.92 full time vacancies in July 2022.

The trust had taken part in recruitment events which had improved the overall vacancy rate within the service. The trust had developed a new workforce model focusing on different skills needed across site to improve the experience of people. Nursing associate (NA) roles were being expanded and the service had recruited 7 new starters into these posts.

Our findings

Managers tried to use bank and agency staff and requested staff familiar with the service. Managers were familiar with most temporary staff who worked on the wards. Managers were able to identify an error where an HCA had been booked into a qualified nursing shift, a ward manager said this had happened before. However, people said there were often bank and agency staff on shift who they did not know.

Managers did not always make sure all bank and agency staff had a full induction and understood the service before starting their shift. On the day of inspection new temporary staff were being inducted by permanent staff members. Both temporary and permanent staff members signed a form to confirm the induction information had been shared and understood. There were gaps where this had not been completed. The induction included contraband items and 'see think act' awareness, which is the importance of keeping professional boundaries in a therapeutic relationship and using knowledge of people to maintain safety. Some people said they did not always feel safe with agency and bank staff on their observations.

The service had a high turnover rate in 12 months. Rainbow had the highest number of staff leaving the service at 29%, Janet Shaw had 27%, Malvern 20% and Eden 10%. In a 12-month period 24 staff left the service, but only 2 people completed exit interviews. Leaders did not consistently use the exit interview process as an opportunity to understand why people left and to find ways to improve staff retention.

Managers supported staff who needed time off for ill health. Human resource staff and ward managers met monthly to discuss staff members who were off sick for more than 4 weeks. An action plan was developed to identify the support a person may need to return to work. Staff were offered a wellbeing call with their line managers. A staff member who had recently returned to work said they had felt supported to return.

Levels of sickness were reducing across the service. Malvern had made the most improvement, sickness levels reduced from 14% in January 2023 to 5% in March 2023. Seven staff were off sick in February 2023, 5 were off with work related injuries/fractures and musculoskeletal conditions.

The service did not always have enough staff on each shift to carry out physical interventions safely, however the Trust has worked to ensure that staff are trained in Safety Interventions.

Managers did not always accurately calculate the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The daily safety huddle reviewed the number of HCAs needed to meet enhanced observations. However, it did not detail acuity and events on the wards that could impact on staff staffing numbers. There were gaps in completing enhanced observations.

The ward manager could not always adjust staffing levels according to the needs of people and there were unfilled shifts across the service.

People had regular one to one sessions with staff, but not always with their named nurse. Permanent nurses said due to qualified nurse vacancies they had to cover one to one sessions for most people and coordinate care as the named nurse role should.

Most people said they rarely had their escorted leave cancelled. However, activities were sometimes cancelled when the service was short staffed. Some people said it was better to be on enhanced observations as staff allocated could take them out on leave. Staff also said people on enhanced observations did not lose their leave when the ward was short staffed for this reason. However, staff and people said activities could be cancelled when staffing levels were low and some people said this happened quite frequently, one person said they found this frustrating. Two members of the

Our findings

Activity Coordination Team (ACT) said they were included in the staffing numbers as HCAs when the site was short staffed. We saw this take place at the time of our inspection. ACT members said they were also used to escort people on leave. On these occasions the activity timetable was suspended across the site. ACT team said the frequency of cancellations was improving. The trust said they worked hard to ensure ACT members were only used when all other options to support safe staffing numbers had been considered.

Staff shared key information to keep people safe when handing over their care to others. We observed a morning handover which included nurses, HCAs and a consultant. The handover shared information about people's general wellbeing, risk, observation levels and incidents. Every person had a positive statement written about them. However, not all staff arrived on time to receive the full handover, some arrived after as it had finished. This meant not all staff were up to date with people' needs and risks when going onto shift.

Following inspection, we issued the trust with a Section 29A Warning Notice from the Health and Social Care Act 2008 requiring them to make significant improvements in relation to staffing levels and to ensure staff caring for people are competent and trained for the environment in which they work.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

The mandatory training programme was comprehensive and met the needs of people and staff, however, not all staff were up to date with their mandatory training, which meant not all staff had the right skills to deliver safe care to people in the service.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward governance minutes prompted staff to keep up to date.

However, staff were not always kept up to date with their mandatory training. Eden was the lowest for information governance training, with 67% of staff completing their training. Resuscitation training was also low on Eden, with 51% of staff trained. Safeguarding adults' level 3 training was also low across site, Rainbow was the lowest with only 33% of staff trained and Malvern the highest with 75%. Only Eden achieved above 95% for safeguarding level 1 and 2. Staff said it was difficult to do online training due to poor signal on the ward and finding time away from observations, they said there was an option to do it at home and take the time back.

We took action following the inspection and told the trust they were required to make significant improvement in relation to staff training levels to ensure staff deliver safe care to people in the service.

Our findings

The trust had taken part in the pilot of the Oliver McGowan mandatory training on Learning Disability and Autism. The trust was in the process of recruiting a lead to roll out the programme within the Integrated Care System. It had also developed 8 online modules on Autism and Mental Health. Fourteen nurses and Allied Health Professionals had competed a course Putting Positive Behavioural Support into Practice. Learning Disability and Autism training was included in the trusts induction, but not part of its mandatory training.

Assessing and managing risk to people and staff

Staff did not always assess and manage risks to people and themselves well. Staff did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to support people's recovery. However, staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating, and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of peoples risk

Staff completed risk assessments for each person on admission, using a recognised tool, and reviewed this regularly, including after any incident. The service used recognised tools such as the HCR20 (V2) and the Steve Morgan Tool. We sampled 10 risk assessments which were regularly reviewed following incidents and changes in people's presentation. Risk assessments were person centred and we saw one written in easy read format for the person.

Management of peoples risk

Staff knew about risks to each person; however, they did not always act to prevent or reduce risks.

Enhanced observations were not always completed in line with the providers' policy and guidelines by the National Institute for Health and Care Excellence. We reviewed 13 enhanced observation charts. There were gaps in charts across all wards. During 1:1 enhanced observation on Eden a HCA was not observing the person they had been allocated. A person told us they had been left on their own whilst on 1:1 enhanced observation. Two people reported they had seen staff asleep whilst on observations.

The trusts policy said staff members should not undertake a continuous period of observation above the general level for longer than 2 hours. HCAs said they completed back-to-back observations, on the day of inspection 10 staff members on Janet Shaw and Eden had completed observations for longer 2 hours. One HCA said they had undertaken patient observations for a 6-hour period without a break, and that this impacted on reading emails and completing on line training.

The trusts updated observation policy included situations in which nurses could adjust observation levels, once agreed with the Responsible Clinician. We reviewed 3 sets of MDT minutes for Janet Shaw, delegating people's observation levels to nursing staff was not discussed. The Trust has confirmed that documentation should be recorded in a patient's observation care plan. An incident had occurred where a person had challenged a staff member observing them as they thought their observation levels had been adjusted and which staff responded to. Without robust governance this policy could lead to an inconsistent approach to levels of restriction for some people, which could lead to incidents. The Trust has explained how it was going to ensure that the policy was implemented robustly.

Our findings

Staff identified and responded to any changes in risks to, or posed by, people. Wards had a grab folder which contained people's positive behavioural support plans and their individual coping strategies, which covered different stages of distress. Staff could respond appropriately to people's needs and understand how to reduce challenging behaviour. However, some staff said not all bank and agency staff had the confidence to intervene and deescalate people who were distressed. Staff said not all agency and bank staff had the skills needed to support people in a secure care environment.

Staff followed procedures to minimise risks where they could not easily observe people. The trust had policies and procedures in place to keep people and staff safe. There were blind spots in areas of the ward and CCTV had been installed in some communal areas. Staff were present in communal areas.

Staff trained in search procedures followed trust policies and procedures when they needed to search people or their bedrooms to keep them safe from harm. However, not all staff were trained to search people and their bedrooms. Only 70% of staff within the service were trained to search. The service intended to offer bank and agency staff this training so they could also search people and their bedrooms.

Following inspection, we issued the trust with a Section 29A Warning Notice to make significant improvements to observations for people, that they are carried out in accordance with trust policy and National Institute for Health and Care Excellence (NICE) guidance to protect people from harm.

Use of restrictive interventions

Levels of restrictive interventions were not reducing in all areas. We reviewed data for the last 12 months. The service had 137 incidents that required people to be restrained by staff. Janet Shaw and Eden totalled 127 of all restraints for the service, Malvern with 10 restraints and Rainbow had none. Eight restraints were in the prone position, holding a person chest down, only one taking place in the past 6 months. At the time of the inspection the numbers of restraint across the services had increased from 8 in February to 23 in March. This was the highest monthly figure all year,18 of these happened on Janet Shaw. Overall, the number of restraints was not reducing.

The service had 84 incidents where people had required seclusion to manage their risk on the ward environment. Fifteen of these happened in the past 6 months, whereas the previous 6 months there had been 69 incidents of seclusion. Rainbow had none. The number of seclusions was reducing overall. The minutes of a governance meeting had reported an occasion where seclusion was identified as having not been reported.

The trusts' blanket restriction policy was out of date and being reviewed. Staff were to avoid blanket restrictions as much as possible, unless it was necessary and a balanced response to a risk which impacted on the wider group. Wards had a list of contraband items displayed for all people. The induction pack included a full contraband list for all new staff. However, people were not kept safe from harm and incidents occurred due to contraband being present on the wards.

People could only access hot drinks at certain time of the day on Malvern ward. On Rainbow people could only take leave once daily tasks had been completed, and the person was looking clean, smart, and tidy. This did not comply with best practice guidance of the Mental Health Act Code of Practice, as this restriction was not related to individual risk. The provider told us they have reviewed their use of ward rules and this no longer applies.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service had recruited a reducing restrictive practice lead who had been in post for 5 months and was based on Janet Shaw. The restrictive practice group held regular meetings for managers and members of the MDT. Restraints and

episodes of seclusion were discussed. From the minutes we read, staff challenged each other to find solutions and best outcomes for people and staff. This group had scheduled sub-groups to involve more staff members. Extra training on relational security and searching had been identified, and bank and agency staff were to be included in that programme. Safety alerts were also shared with the group.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep people or others safe.

Positive Behavioural Support (PBS) plans were kept in a grab folder in the staff office for quick access. Plans were detailed with people triggers, early warning signs and coping strategies to help staff deescalate situations and support people to keep calm.

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

Staff followed NICE guidance when using rapid tranquilisation. Staff monitored people's physical health after using rapid tranquilisation. Rapid tranquilisation (RT) is the use of medication, usually an injection, to reduce aggression where people maybe placing themselves or others at risk. The service had used RT on 42 occasions, 32 of these had been on Eden. Rainbow had none. Whilst the total usage for March was the second highest all year, the evidence showed in the last 6 months use of RT was lower than the previous 6 months.

When a person was placed in seclusion, staff did not always keep clear records and follow best practice guidelines. This meant that staff did not always give due regard to the human rights of those secluded. Staff did not always complete seclusion reviews as set out in the Mental Health Act Code of Practice. We reviewed 7 sets of seclusion reviews and found there were gaps in recording daily reviews, body maps, and the time seclusion had ended. The trust had completed internal audits which identified similar themes and the reducing restrictive practice minutes in January 2023 noted not all episodes of seclusion were being recorded. This meant that not all seclusion could have been effectively reported.

People were sometimes cared for away from others on the ward to reduce the risk posed to others. Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a person was put in long-term segregation (LTS). This meant that staff did not give due regard to the human rights of those segregated. The service had 4 people in long term segregation (LTS). This had reduced from 6 people over the past 2 months. Daily reviews for people in LTS were not always recorded accurately, and some had gaps. Monthly reviews of LTS were thorough and had identified gaps in the daily reviews, with prompts to HCA and nurses to complete observation records and daily reviews. It was not clear who was taking responsibility for the actions identified from monthly reviews as often people had the same actions identified at each review. The monthly review also noted gaps in the doctor's daily review, with 3 out of 6 days missing for 1 person.

The Mental Health Act reviewing team completed a LTS review at Brooklands in February 2023. The review found the living area on Eden did not meet standards set out in the Mental Health Code of Practice (26.151) as there was no separate lounge. Staff did not always fully complete seclusion records, and often had poor-quality information in them. In some cases there was no re-integration plan and was not always clear that the person had been informed of what needed to happen for LTS to come to an end.

We took action following the inspection and told the trust they were required to make significant improvement in relation to its compliance with the Mental Health Act Code of Practice for long-term segregation and seclusion practice.

Our findings

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse and knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Not all staff were up-to-date with their safeguarding training. Across the service 97% of staff had completed level 1 safeguarding children training. However, only Eden achieved over 95% of staff trained in level 1 adult safeguarding. Safeguarding adults level 3 training ranged from 33% on Rainbow to 75% on Malvern.

Staff could give clear examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act. The service had a high level of compliance for Equality and Diversity, with Eden and Rainbow having 100% of staff trained, Janet Shaw 92% and Malvern 85%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The trust's safeguarding lead visited Janet Shaw every other week, this was put in place following concerns raised during the previous inspection. The trust's safeguarding team met every other week with the safeguarding lead from the local authority. Safeguarding champions were in place across the wards, with a 3 monthly meeting to share themes across services and lessons learnt.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes. Managers and clinical leads attended a monthly meeting with the safeguarding lead from the trust, this was new and only one meeting had taken place so far.

Staff access to essential information

Staff did not always have easy access to clinical information which meant it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

People's notes were mostly comprehensive, and these comprised of a mixture of paper and electronic records. Staff said they did not always have access to the most accurate and up to date information, including care plans and risk assessments. Care notes had been unavailable between August 2022 to January 2023 due to a national incident. Staff said not all care notes had been fully uploaded from this incident and 3 staff said their access to the system had still not been resolved. One staff member said care notes went down "quite frequently," 2 other staff members said it had been down recently, prior to inspection. Staff wrote notes on a word document stored on the trusts hard drive and added them to care notes when it was working. During our inspection the internet was down, care notes could not be accessed which meant people's records could not be viewed. However, staff had access to paper records for care plans risk assessment and PBS plans. Staff told us this had impacted external teams completing assessments for people. This meant there was an impact for staff making clinically informed decisions.

When people transferred to a new team, there were no delays in staff accessing their records. However, transfers would have been impacted by the electronic care notes system not working.

Records were stored securely.

Our findings

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each person's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff recorded and monitored fridge and room temperatures. The records we reviewed on site were in order. The trust regularly audited this and acted where needed.

Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines. Staff reviewed people's records during MDT meetings and discussed medicines with them.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 12 prescription records and saw that these were accurate.

Staff stored and managed all medicines and prescribing documents safely. The pharmacist visited the service weekly, during inspection we observed a pharmacy audit.

Staff followed national practice to check people had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service did not overuse 'as required' medication to manage people' behaviour.

Staff reviewed the effects of each person's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a variable track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. However, staff did not always report incidents of ingestion consistently. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them. Managers reviewed incidents on a regular basis. The trust produced bulletins for staff which included 3 top learning points.

Staff did not consistently report incidents and near misses in line with trust/provider policy. We found inconsistencies in the number of reported incidents related to ingestion which did not match the frequency reported to us by staff, and concerns documented in governance and MDT minutes. We requested 12 months data regarding incidents related to ingestion, and the trust reported 8 incidents. Staff and external professionals, including an anonymous whistle-blower, raised concerns regards the number of incidents related to ingestion. We reviewed MDT minutes for Janet Shaw in March 2023 and found 14 incidents related to risk of ingestion. Governance minutes for Janet Shaw January 2023 stated,

Our findings

“concerns raised around swallowing screws and or batteries and has become unacceptable and need to manage this risk”. Governance minutes for Rainbow, Malvern and Eden reported issues with contraband on the unit with no robust, consistent process for searching people on return from leave. Staff we spoke with could share examples of when and how they had reported an incident, and feedback they had received having done so.

We took action following the inspection and told the trust they were required to make significant improvement in relation to learning from incidents.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Following incidents the service offered a trauma-focussed peer support system to staff. One staff member said they had accessed this and found it to be supportive.

Managers investigated incidents thoroughly. People and their families were involved in these investigations. However, 3 out of 4 families said they did not receive feedback following an incident that had occurred.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to care. Staff could attend a fortnightly learning from incident group which had started in January 2023. The group reviewed a selection of incidents, discussed themes and shared learning. However, minutes from this group were not taken and learning was not shared with staff who were unable to attend. The trust also had a monthly reflective practice group that staff could book on to. Bulletins were shared via email, however managers acknowledged HCAs did not always have the time to read their emails.

There was evidence that changes had been made as a result of feedback. At the last inspection people and staff said they did not always feel safe. The trust had employed a lead for reducing restrictive practice. During this inspection some staff said they felt they were more confident in managing difficult situations and that boundaries between staff and people were improving. A training package was being developed on positive behavioural support to be included within restraint training and this would be offered to bank and agency staff, as well as permanent staff.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Our findings

Assessment of needs and planning of care

Staff assessed the physical and mental health of all people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected people's assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after.

All people had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each person that met their mental and physical health needs. The 12 care plans we reviewed were detailed and individualised to people's needs. Care plans had input from outside agencies where appropriate.

Staff regularly reviewed and updated care plans when people' needs changed. People were included in reviewing their care plans and said they had a copy of their care plan.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. They ensured that people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the people in the service. People had access to a range of psychological therapies, both group and individual sessions. These included a thinking skills programme which included offender treatment modules, substance misuse groups and dialectical behavioural therapy. People completed a 12 week admission assessment which identified a treatment pathway.

Staff delivered care in line with best practice and national guidance from National Institute of Clinical Excellence. When people were ready to move on to other services the psychology team would deliver training to that service to help them understand people's past experiences and how that impacted on their current presentation, and the therapeutic skills needed to work with the person.

Staff identified people's physical health needs and recorded them in their care plans. The service had employed a physical health nurse and people had health action plans in place. The trust had also employed a specialist epilepsy nurse. We saw detailed, clear and concise epilepsy care plans. Eden worked hard to ensure women's health checks were in place, including routine breast screening and cervical screening.

Staff made sure people had access to physical health care, including specialists as required.

Staff met people's dietary needs, and assessed those needing specialist care for nutrition and hydration. Specialist diets were available for people with specific dietary and cultural needs. However, 4 people with specific dietary requirements said there was poor choice in food, 2 people said they relied on family visiting to bring food in as the halal choice was limited and "horrible".

Our findings

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. The service had a gym on site and Janet Shaw had a gym room on the ward. One person said the equipment was poor, and another said they did not have as much access to the gym as they would like as staff were not always available to escort.

Staff used recognised rating scales to assess and record the severity of people' conditions and care and treatment outcomes. The service used the Health of the Nation Outcome Scale (HoNOS). This measures people's behaviour, impairment, symptoms and social functioning.

Staff used technology to support people.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Ward managers and matrons took part in a regular programme of audits.

Managers did not always use results from audits to make improvements. At the time of inspection body maps and seclusion end times were still not routinely completed, these were actions identified in the quarterly audits in September 2022 and December 2022

Skilled staff to deliver care

The ward teams had access to the full range of specialists required to meet the needs of people on the wards. Managers provided an induction programme for new staff. Managers did not always ensure they had staff with the range of skills needed to provide high quality care. Managers mostly supported staff with appraisals and opportunities to update and further develop their skills, but did not always support staff with supervision.

The service had access to a full range of specialists to meet the needs of the people on the ward. Each MDT consisted of a variety of professionals including psychiatrists, occupational therapists, psychologists, and nurses. There were 2 vacancies for psychologists which had been advertised. The occupational therapy team had successfully recruited into vacant posts, however it still had a vacancy rate of 10%.

Managers gave each new member of staff a full induction to the service before they started work. The induction pack was specific to secure services and there was a local ward induction checklist. However there were gaps in the ward induction used for bank and agency staff.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. Staff said bank and agency staff were not always familiar with working in a secure environment and not all had the confidence in deescalating difficult situations on the ward. The service said it intended to include regular bank and agency staff in training led by the reducing restrictive practice lead, such as relational security and how to search people. Some people said they felt less safe with bank and agency staff.

Managers mostly supported staff through regular, constructive appraisals of their work. In February 2023 77% of staff on Rainbow had received an appraisal. Janet Shaw had the highest number of staff appraisals at 88%.

Managers did not always support staff through regular, constructive clinical supervision of their work. The trust's local supervision policy said staff should have supervision at least once in an 8-week period. However, from February to April 2023 only 30% of staff on Janet Shaw had received supervision, 53% of staff on Rainbow, 67% on Malvern and 75% on Eden. Two permanent staff nurses reported feeling burnt out with the lack of permanent nurses and additional work it caused them. Clinical supervision would have been a space for them to access support and reflect on their practice and values.

Our findings

Managers did not make sure staff attended regular team meetings. Staff meetings did not take place regularly on all wards. Janet Shaw and Eden had no team meetings taking place. Malvern's monthly team meetings had only started in February 2023, and 2 had taken place. Rainbow had 5-minute feedback sessions, these had been minuted 3 times in 4 months. Without regular meetings staff would not have the opportunity to raise issues and be kept informed of change. Staff could attend a learning from incidents group, these were meant to happen fortnightly however in 3 months only 2 meetings had taken place.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers had been offered leadership training and we spoke to HCAs who were doing their Nurse Associate training. Fourteen nurses and Allied Health Professionals had competed Putting PBS into Practice course.

Managers made sure staff received any specialist training for their role. The service ran a quarterly 3-day induction programme, delivering training specific to its secure learning disability and autism service. This included relational, physical, and procedural security, PBS and therapeutic engagement. Lessons learnt from poor practice was covered and the importance of safeguarding, closed cultures and speaking up.

Managers recognised poor performance, could identify the reasons and dealt with these. The service actively used their policies to address poor performance and had taken decisions to suspended staff form the service where appropriate.

We took action following the inspection and told the trust they were required to make significant improvement in relation to staff supervision and team meetings.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular MDT meetings to discuss people and improve their care. These were attended by different professionals within the hospital, including psychology and occupational therapy. People and external professionals also attended and contributed to these meetings.

Staff made sure they shared clear information about people and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation and with external teams and organisations. Case managers from the local provider collaborative attended MDT meetings.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain people' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Our findings

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

People had easy access to information about independent mental health advocacy and people who lacked capacity were automatically referred to the service. Information about advocacy was displayed on the ward on the information board. Advocates visited wards regularly and people knew how to access them.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the people's notes each time.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of people' detention papers and associated records correctly and staff could access them when needed. This included keeping copies of medication authorisation certificates within the prescription charts.

Care plans included information about after-care services available for those people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

People discharged from the service were sometimes placed under a deprivation of liberty safeguards (DOLS). This pathway was in action for some people, staff were able to tell us about the DOLS process.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. People's capacity was discussed in MDT reviews, for example a capacity assessment was planned for a person relating to their finances, staff had raised concerns about spending habits and the potential for exploitation.

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered the person's wishes, feelings, culture and history. However, the trust's audit said it needed to get better in telling people the outcome of those assessments.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision.

Our findings

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited annually how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement 

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat people with compassion and kindness. They respected people's privacy and dignity. They did not always understand the individual needs of people and supported people to understand and manage their care, treatment or condition.

Staff were discreet, people said staff knocked on their doors before entering. Most people spoke highly of regular staff, that staff treated them well and behaved kindly. However, 5 people said temporary staff did not care for them in the same way. Some people said bank and agency staff were not always respectful, and responsive when caring for them. One person said they felt "uncomfortable" when temporary staff were carrying out enhanced observations as they did not always interact with them. Another person shared this view and that it made them feel "paranoid". Two people said agency staff would watch TV, rather than interact with them. During inspection we observed interactions between people in the service and staff. These interactions focused mainly on immediate needs, such as people asking for a restricted item out of their locker, and did not involve day to day social interactions outside of task based activities.

People said regular staff gave people help, emotional support and advice when they needed it.

Staff directed people to other services and supported them to access those services if they needed help.

Staff mostly supported people to understand and manage their own care treatment or condition. People had a copy of their care plan and were aware of their treatment pathway. Staff did not always understand and respect the individual needs of each person. Some staff said there was a lack of consistency on the wards due to high use of bank and agency staff who were unfamiliar with the people. Staff said bank staff ran night shifts and governance minutes for Rainbow supported this. People told us that the high use of bank and agency staff impacted on the standard of care they received.

One person said care was poor on nights, that staff were not always seen on the ward and did not always answer the office door when they knocked. Two people said they had seen staff using their mobile phones at night, mobile phones were not allowed on the unit.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. Freedom to speak up guardian's details were displayed on the ward and how staff could make contact.

Staff followed policy to keep people's information confidential. However, the service had low mandatory training numbers for information governance.

Our findings

Involvement in care

Staff involved people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that people had easy access to independent advocates.

Involvement of people

Staff introduced people to the ward and the services as part of their admission. There were information booklets on all wards.

Staff involved people and gave them access to their care planning and risk assessments. People said they had copies of their care plans, and that they felt involved in their care and treatment.

Staff made sure people understood their care and treatment and found ways to communicate with people who had communication difficulties.

Staff did not always involve people in decisions about the service, when appropriate. Community meetings were not taking place on Eden and Rainbow. Janet Shaw's weekly therapeutic community meeting was due to take place whilst we were inspecting, however this did not happen and people were not told why. Three people said they did not have an opportunity to feedback on the service. People on Malvern had a morning meeting, we observed this to be inclusive with a positive atmosphere

Most of the time people could give feedback on the service and their treatment and staff supported them to do this. Most people attended their weekly MDT review and their feedback was included in the minutes. People could use an online app 'I want great care' to feedback on the service. This covered several areas including the persons experience, staffing, safety, cleanliness and food. This had been completed 79 times in 6 months. People also completed an EssenCES interview every 3 months to capture their experiences of culture and safety of the ward. Janet Shaw had the lowest results compared with other wards, people felt safety and support was low and peer relationships were poorer on this unit compared to others. However Janet Shaw had improved is score for peoples experience of safety over the past 3 months.

Staff supported people to make advanced decisions on their care.

Staff made sure people could access advocacy services. The information board displayed how to contact advocates. However, on Janet Shaw advocates were not routinely attending weekly MDT meetings with people.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Three out of 4 families gave an example of when staff had not kept them fully informed of an incident and given feedback from a complaint made.

Families were invited to Care Programme Approach meetings and Care and Treatment Reviews in which they could give feedback on the service. The service had developed a carers forum that started in October 2022.

Staff gave carers information on how to find the carer's assessment.

Our findings

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

Access and discharge

Staff did not always plan and manage peoples discharge well, sometimes people had to stay in hospital when they were well enough to leave. However, they worked well with services providing aftercare and managed people's moves to another inpatient service.

Bed management

Managers made sure bed occupancy did not go above 85%. The service had been going through a refurbishment and bed numbers had been kept low to allow this to happen. Janet Shaw, Malvern and Eden were at 63% occupancy at the time of inspection. Rainbow however had 100% occupancy for 9 out of 12 months.

Managers did not effectively review length of stay for people to ensure they did not stay longer than they needed to. People did not have an up to date expected discharge date. Care and Treatment Reviews (CTRs) are for adults with a learning disability or autism and in secure services should happen yearly. They are carried out by an independent panel of people, an expert by experience, a clinical expert, and the commissioner. CTRs make recommendations about the safety, care and treatment of people and aim to reduce the amount of time people spend in hospital. Most people in the service had their CTRs within the yearly timeframe, however 7 out of 26 people had not.

The service had no out-of-area placements. The admission of people from across the region was the clinical model for secure services'. The service said they worked in collaboration with regional commissioners.

Managers and staff worked to make sure they did not discharge people before they were ready.

When people went on leave there was always a bed available when they returned.

People were moved between wards only when there were clear clinical reasons or it was in the best interest of the person. A person said they told staff they felt bullied by a peer on the ward, staff listened and agreed a transfer which they were happy about.

Staff did not move or discharge people at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of people whose discharge was delayed, knew which wards had the most delays, and took some action to reduce them.

Eleven people had experienced delays in their discharge over the past 12 months. Nine people had been waiting for community placements, 2 people had been waiting for transfers within secure services. Not all people had an expected discharge date, the service did not effectively plan for discharge and mitigate for delays. However, managers had monthly meetings with Reach Out Provider Collaborative to discuss people who were experiencing delays in their pathway.

Our findings

People sometimes had to stay in hospital when they were well enough to leave. Managers said this was due to a lack of community placements for people to move on to.

Staff carefully planned people' discharge and worked with care managers and coordinators to make sure this went well. Staff wrote service specifications for people who were ready for discharge, these were shared with community providers to ensure they understood the person's current needs and history. Psychology staff delivered bespoke training packages to the new provider who would be responsible for person's care on discharge.

Staff supported people when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was not of good quality and people could not make hot drinks and snacks at any time.

Each person had their own bedroom, which they could personalise.

People had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and people could access the rooms.

The service had quiet areas and a room where people could meet with visitors supervised by staff.

People could make phone calls in private, or supervised by staff where care planned to do so.

The service had outside spaces and gardens that people could access with staff supervision.

People could not make their own hot drinks and snacks and were dependent on staff. We led a focus group with 3 people on Malvern, they said hot drinks were only allowed at quarter to the hour. A person on Eden said it was difficult to get a drink on general observations as staff were too busy to support people on general observation. People had supervised access to a therapy kitchen which was risk assessed individually and so only applied to some people.

The service did not offer a variety of good quality food. Food was regenerated, cooked elsewhere and transported on to site and reheated. Managers said food was a common compliant from people. Eight people said the food was poor with little choice, one person said food was "disgusting". The focus group on Malvern said food was poor and they would like to be more involved in developing the menu. During May, June and July 2022 feedback sessions took place and a new menu was launched in August 2022. However, people continued to be dissatisfied with the food on offer.

People' engagement with the wider community

Staff did not always support people with activities outside the service, such as work, education and family relationships.

Staff did not ensure people had access to opportunities for education and work, and supported people.

Our findings

The provider collaborative said people did not have enough educational opportunities. Some people said they did not have access to meaningful activities. People did not have access to an individualised timetable unless in LTS, and one out of 4 people in LTS also did not have access to an individualised timetable. The service did not follow the Right Support, Right Care, Right Culture model of care which specifies providers should focus on people shaping their own meaningful activities, independence, and quality of life. Most people said they wanted more activities, some people said there were no activities at the weekend.

Staff helped people to stay in contact with families and carers.

Staff encouraged people to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service did not always met the needs of people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities and those with communication needs or other specific needs.

Activity Co-ordination Team displayed a ward timetable of activities, information about these activities was supported with pictures to make it more accessible and easier to understand.

Staff made sure people could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the people and local community.

Managers made sure staff and people could get help from interpreters or signers when needed.

The service did not always provide a variety of food to meet the dietary and cultural needs of individual people. People who ate Halal food said they had a limited options and it was of poor quality.

People did not always have access to spiritual, religious and cultural support.

There were multifaith rooms across the service. However, the room on Rainbow could not be accessed as a space for contemplation or prayer as it was full of people's belongings.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

People, relatives and carers knew how to complain or raise concerns. People and families said they knew how to raise their concerns.

The service clearly displayed information about how to raise a concern in ward areas.

Staff understood the policy on complaints and knew how to handle them.

Our findings

Managers investigated complaints and identified themes. Over a 12 month period the service had received 8 complaints, in 4 of these feeling safe on the unit was a theme.

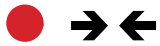
Staff protected people who raised concerns or complaints from discrimination and harassment. Staff safeguarded people who had complained of experiencing bullying on the unit, actions were put in place to support people. One person said they felt listened to when they raised concerns about bullying.

Staff knew how to acknowledge complaints and people received feedback from managers after the investigation into their complaint. People and their families made complaints which were investigated. Outcomes and actions were identified and discussion took place with people to offer reassurance. However families reported they did not always get feedback.

Managers shared feedback from complaints with staff, however learning was not always used to improve the service. People, staff and managers said complaints had been raised about the quality of food and this did not seem to be improving.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and but were not always visible in the service and approachable for people and staff.

Four staff, including 2 managers, said senior leaders from the trust did not visit the wards. Scheduled drop-in sessions took place every two weeks at the hospital site.

Staff were complimentary about their immediate managers and service leads. We saw ward managers supported clinical duties during busy periods and had a good rapport with staff on the wards.

Managers had opportunities to develop in their leadership roles. A new manager network had been developed across the trust to support managers develop management skills and learn from each other.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The trust relaunched their strategy and vision last year, Rainbow was chosen to promote this within the wider trust. Some staff were able to describe to trusts values and how they saw them applied day to day.

Our findings

Culture

Staff did not always feel respected, supported and valued by senior managers. However, they said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Permanent nurses said they felt burnt out from doing additional hours and extra tasks due to a shortage of permanent nurses in the service. One nurse said senior managers did not acknowledge how being short staffed impacted on permanent staff, “they don’t care about how things are, no email to reach out and say thank you”.

Supervision rates were low across the service which meant staff were not formally supported with their clinical decision making and practice on a regular basis.

However, staff spoke positively about other permanent staff in the service and described good teamwork and a supportive culture.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Following inspection, we issued the trust a Section 29A Warning Notice to make significant improvements to the governance of the service, to ensure it is effective in reducing and mitigating risk and improve the quality of care for people.

Team meetings did not take place frequently and there was limited feedback between staff and managers. Staff did not have a regular forum to share their concerns, and this did not promote staff inclusion in decision making and service development.

Learning from incidents group was in place across the service, however these were not regular. Managers did ensure staff received information about incidents through emails but the infrequency of team meetings meant there was limited oversight and follow up of actions to embed change. Staff told us they did not always have time to read their emails.

Although systems and processes were in place to monitor compliance with training and supervision, these were not always effective. Compliance rates for some mandatory training and clinical supervision was low. The service was not hitting its own targets for delivering supervision across the service.

There was a lack of oversight on the quality of enhanced observations and restrictive practices within wards, although the service was aware and had put in place arrangements to improve monitoring, including a senior led group to focus on Restrictive Practice Interventions

Regular governance meetings for the service took place and managers attended these. A ward governance bulletin was sent out to staff following these meetings, however only Janet Shaw could evidence this.

The restrictive practice group was newly set up and in the process of developing sub-groups to include more staff.

Our findings

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

Electronic care records were not working for part of the inspection, and had not been working for some months prior due to a national program issue. Staff said there was a back log in processing people's information which had been stored elsewhere, and that it was for nurses and ward clerks to decide who had capacity in their day to move notes across to care notes. There was not a robust process for moving a person's information between systems. Staff did not have access to all people's information to make clinically informed decisions. Staff said this had impacted an assessment from a community provider, as not all the information was available to review.

The service had a process for recording incidents on to an incident reporting system. Not all incidents were being recorded accurately. For example, the number of ingestions reported through incident data did not correlate with concerns raised in governance meeting, MDT meetings and by staff during our interviews. Leaders did not always have effective oversight of the levels of risk within their service and take appropriate action to mitigate against the risk recurring.

From the seclusion, LTS and observation audits, actions were identified. However, there was no ownership of these actions, and audits did not always lead to improvements.

We reviewed the quality improvement plan (QIP) and minutes from November 2022 to February 2023. The trust had embedded required improvements from the last CQC inspection into the QIP. Actions had a timeframe and were rated according to progress made. However, we were concerned some outcomes were slow to progress. For example, improving supervision was identified at the last inspection and remained a concern, staff burn out was noted in the November 2022 QIP minutes and staff continued to report this during our inspection.

The service had a risk register in place which was regularly reviewed and monitored.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service took part in peer reviews and national Quality Network for Forensic Mental Health Services (QNFMHS).

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Teams worked closely with the West Midlands provider collaborative to offer a local pathway for people. Managers liaised with local authorities, integrated care boards, and other health care providers to support people's discharge and progress through their pathway. Staff from health and social care providers were invited to discharge meetings, and section 117 after care meetings where appropriate. These meetings ensure people detained under a section 3 of the mental health act have their needs met on discharge and reduce the risk of the person returning to hospital. However, delayed discharges were not effectively mitigated for and there were delays in people leaving the service.

Our findings

Learning, continuous improvement and innovation

Managers used quality improvement methodologies to implement changes and improve people's experience and outcomes. The lead for the QIP said they measured whether change was embedded. For example, cleaning had improved across site, audits were used to assure the trust this change was embedded in practice.

Our findings

Areas for improvement

Core service forensic inpatient services

Actions the service MUST take to improve:

- The trust must ensure its staff carry out observations in accordance with trust policy and National Institute for Health and Care Excellence (NICE) guidance to protect people from harm. (Regulation 12 (1))
- The trust must ensure it adheres to the Mental Health Act Code of Practice in relation to record keeping, timely reviews and governance of people in long term segregation and seclusion practice. (Regulation 12 (1))
- The trust must ensure the secure environment is fit for purpose and meeting the needs of people, and that environment checklist are robust enough to identify harm and reduce risk to keep people safe from harm. (Regulation 12(1))
- The trust must ensure that it has enough qualified and unqualified nursing staff to keep people safe from avoidable harm. (Regulation 18(1))
- The trust must ensure staff caring for people are competent and trained to effectively carry out their duties, appropriate for the environment in which they work. (Regulation 18 (1))
- The trust must ensure that staff receive regular supervision and adhere to their own policy. (Regulation 18 (1))
- The trust must ensure staff receive all statutory and mandatory training required to effectively carry out their duties. (Regulation 18 (1))
- The trust must ensure the governance of the service is effective in identifying, reducing and mitigating risk, improving the quality of care for people. (Regulation 17 (1))
- The trust must ensure staff can view and update accurate, contemporaneous care records. (Regulation 17(1))
- The trust must ensure blanket restrictions are only used as proportionate responses to identified risks. People must receive person centred care and treatment that is appropriate, meets their needs and reflects personal preferences. (Regulation 9 (1))
- The trust must ensure that activity workers function effectively in their roles to meaningfully occupy and support the people in their care pathway (Regulation 9 (1))
- The trust must ensure all people have an individualised timetable in accordance with National Institute for Health and Care Excellence (NICE) guidance quality statement 7 (Regulation 9 (1)).

Actions the service SHOULD take to improve:

Core service forensic inpatient service

- The trust should ensure staff are accurately documenting people's incidents, to draw themes from and share lessons learnt.
- The trust should ensure staff take regular breaks from enhanced observations, in accordance with trust policy.

Our findings

- The trust should ensure its policies incorporate standards for the physical environment provided for all people segregated, and how this will be monitored through governance at all levels of the organisation.
- The trust should ensure that staff meet regularly as a team to raise concerns and issue affecting the service.
- The trust should ensure temporary staff are given training in relational security at a level appropriate for a secure environment.
- The trust should ensure its induction programme is sufficient for temporary staff for people to feel safe and have confidence in their care.
- The trust should ensure it has effective oversight of its high staff turnover rate and is carrying out exit interviews to develop meaningful staff retention plans.
- The trust should improve the quality of food offered to people, and that there are suitable alternatives for those with specialised diets.

Our inspection team

We conducted an unannounced comprehensive inspection.

We visited 4 wards

We conducted the following tasks:

- Looked at the ward layout and environments
- spoke with 35 staff
- reviewed 12 care records
- reviewed 12 prescription charts
- spoke with 19 people and 4 carers
- conducted observation in communal areas
- observed a daily safety huddle
- observed a morning meeting
- looked at a range of documentation including policies, standard operating procedures, MDT reviews, reports and meeting minutes.

What people who use the service say

We spoke with 19 people who use services and 4 carers.

People said wards were short staffed and there was a reliance on bank and agency staff.

Some people said they did not always know the names of those looking after them, that they did not always feel safe with bank and agency staff and that bank and agency staff did not always interact with them.

Most people were positive about regular staff and said they were kind and understood their needs.

People said there wasn't always enough activities on offer on the wards and described a lack of activities on evenings and weekends. People said activities could be cancelled due to staffing numbers.

People said they and had a copy of their care plan and could attend their MDT meeting regularly to see their care team.

Feedback on the quality and variety of food was generally poor.

Some carers they said that they weren't always informed of incidents that had taken place and that they did not always receive feedback from investigations.

Carers said they felt people were safe.

Most people said they felt safe.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance