

Stockton Hall

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

Summary of findings

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

Overall summary

Stockton Hall is a 112-bed medium secure hospital that provides treatment for people over 18 with mental health problems, personality disorders, autistic spectrum disorders and learning disabilities.

Our rating of this service stayed the same. We rated it as requires improvement because:

- Not all ward environments were clean or well maintained. The environmental issues and the way staff managed patients' bathroom access in seclusion impacted on dignity, and some patients reported that staff spoke to them in an abrupt way.
- Not all staff were aware of ligature points and measures were not in place to manage blind spots on a number of the wards, which could impact patient safety.
- Patient autonomy was impacted by multiple blanket restrictions in place on wards. Staff did not apply individualised risk assessments to elements of patient care, such as access to outdoor areas being limited to daylight hours and activity rooms on some wards being locked. The service's reducing restrictive practice group had not recognised some of the restrictions identified, had not appropriately assessed others and wards had failed to implement agreed actions for others.
- Staff rotas did not consistently demonstrate that there was an appropriate number or skill mix of staff on shift. Staff were regularly required to work on other wards within the hospital, but these moves were not documented.
- The quality assurance processes lacked oversight, governance structures were not consistently implemented or effective. Meetings were cancelled; and meeting decisions were not always documented. The service's auditing processes were not effective in ensuring that staff maintained accurate documentation in relation to multiple aspects of client care, including documentation of their capacity, seclusion and daily care notes.

However:

- Staff minimised the use of physical interventions and seclusions, generally managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Fenton ward was the first medical facility in the country to be awarded an advanced award by the Autism Accreditation Award Committee and the ward had specialised facilities to support recovery.
- Most patients reported that staff treated them with kindness, respect and dignity. The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Patients were supported to pursue vocational activities both within the hospital and in the local community; and the hospital had facilities to support patient hobbies, such as a music studio and woodwork room.
- The service enabled staff to pursue further learning and qualifications; such as radically open dialectical behavioural therapy training. The ward staff worked well together as a multidisciplinary team and with external agencies to meet the needs of patients. Staff planned and managed admissions and discharges well and liaised with services that would provide aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Most staff treated patients with compassion, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Summary of findings

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Requires improvement 

Stockton Hall

Services we looked at

Forensic inpatient or secure wards

Summary of this inspection

Background to Stockton Hall

Stockton Hall is a 112-bed medium secure hospital within the Priory Group. It provides treatment for people over 18 with mental health problems, personality disorders, autistic spectrum disorders and learning disabilities. The hospital admits patients from across England.

Stockton Hall is registered with the Care Quality Commission (CQC) to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983,
- diagnostic and screening procedures, and
- treatment of disease, disorder or injury.

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection. A registered manager is a person who has registered with the CQC to manage the service. Registered persons have the legal responsibility for the service meeting the requirements of the Health and Social Care Act 2008 and associated regulations. An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

The hospital has seven wards:

- Hambleton Ward, an eight-bed ward for men with more settled in presentation and typically older adults with mental illness and / or personality disorders;
- Fenton Ward, an eight-bed ward for men with autism spectrum disorders;
- Kyme Ward, a 16-bed ward for men with learning disabilities;

- Dalby Ward, a 16-bed ward for men with personality disorders;
- Farndale Ward, a 16-bed ward for women with mental illness and / or personality disorders;
- Boston Ward, a 24-bed ward for men with mental illness;
- Kirby Ward, a 24-bed ward for men with mental illness.

The hospital has been inspected by the CQC on five previous occasions. The last comprehensive inspection took place 22 to 24 May 2018, the hospital was rated requires improvement overall, they were rated requires improvement in the safe and well led domains, and good in the effective, caring and responsive domains. The hospital did not meet two regulations of the Health and Social Care Act (Regulated Activities) 2014 as patients did not routinely have access to a nurse call system and the hospital's audit systems in place were not always effective; for example, in relation to the discharge planning records, the inconsistent use of systems to record information about the patients and implementation of Priory policies.

We reviewed whether the provider had made the required improvements during this inspection and found that the provider had introduced a call bell system and Priory policies had been embedded. However, the required improvements had not been made to governance processes and maintaining accurate documentation. We also had concerns about the use of blanket restrictions, and maintenance of ward environments, including patient access to toilets in seclusion.

Our inspection team

The team that inspected the service comprised three CQC inspectors and three specialist professional advisors; two nurses and one occupational therapist.

Summary of this inspection

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information. We sought feedback from staff and patients during focus groups held 03 January 2020. We spoke with 34 staff members at three focus groups, including allied health professionals, nurses and health care support workers; and spoke with 17 patients at ward specific focus groups.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- reviewed seven seclusion rooms;
- spoke with 28 patients who were using the service and two carers;
- spoke with the managers or acting managers for each of the wards;

- spoke with three senior managers: the director of clinical services, the operational director for the North and the regional support services manager;
- spoke with 31 ward staff; including doctors, nurses and health care support workers;
- spoke with 14 allied health professionals; including occupational therapists, assistant psychologist, social workers, fitness instructors, technical instructors, drama teacher, dietician, ward clerk, security staff and domiciliary staff;
- received feedback about the service from three care co-ordinators or commissioners;
- attended and observed four patient activities, two seclusion reviews, and two multi-disciplinary meetings;
- collected feedback from 12 patients using comment cards;
- looked at 20 care and treatment records of patients;
- reviewed three rapid tranquilisation monitoring forms and seven seclusion records;
- carried out a specific check of the medication management on all wards and reviewed 66 medicine cards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During inspection we spoke with 28 patients who were using the service and two carers, collected feedback from 12 patients using comment cards, and spoke with 17 patients at ward specific focus groups during the month of inspection.

Patients spoke mainly in positive terms regarding the staff, stating that they were “caring”, “listen to me” and

“go above and beyond”, and they felt that staff were “genuinely interested” and invested in patients’ wellbeing. However, some patients felt that staff could come across as “mickey taking” or “abrupt”.

Summary of this inspection

Most patients reported that staff respected their privacy and treated them with dignity. However, three reported that staff did not knock before entering their room and one patient informed us that staff had not removed bedpans from seclusion in an appropriate timeframe.

Patients reported that there was always a staff member available on the ward and most reported that activities and Section 17 leave could be rearranged but was rarely cancelled, though Dalby and Boston patients said staffing could impact on this. Patients reported that staff were available for support and that they would plan increased support for patients during difficult anniversaries.

Patients were very complimentary of the different activities and therapies on offer at the hospital, and the input of the multidisciplinary team. All patients spoken had multiple allied professionals involved in their care and were involved with activities such as the gym, woodwork, English lessons and vocational work inside and outside the hospital. However, patients reported that they were bored at weekends. Many patients also stated that the food was not of an acceptable quality or quantity.

Patients and carers told us they were supported to maintain their relationships and facilitated regular contact and visits. The hospital facilitated quarterly events for patients and carers to attend, such as a summer barbecue. Both patients and carers were very positive and appreciative of this and the service had received a lot of compliments about this provision.

Patients reported that they had been involved in their care planning and all knew their plan for treatment

progression and discharge. Carers were involved in and invited to attend patient care reviews. They were provided with information regarding their medicine and treatment choices and had been involved in these decisions. They reported that they had easy and timely access to a doctor.

Patients were positive about some of the reduced restrictions within the service, such as the recent introduction of mobile phones. However, they also reported a number of blanket restrictions were still in place, such as a set time to retire to their bedrooms in the evenings and access to outside areas being restricted to daylight hours.

Patients from all wards raised concerns around ward cleanliness. Patients from all wards except Hambleton and Farndale wards also raised concerns around ward maintenance and said the environment was “tired” and needed “updating”. Four of the 24 bedrooms on both Boston and Kirby were en-suite, the remaining patients shared bathroom and toilet facilities and reported that these facilities were often dirty and poorly maintained.

Patients were given opportunities to give feedback on the service in surveys, within community meetings and service user forums. Patients were able to input into hospital groups, such as the reducing restrictive practice group, and were involved in staff interviews. They felt that they could report complaints or concerns without fear of repercussions. Patients who had made complaints said they had received an appropriate response to their concerns.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of this service stayed the same. We rated it as requires improvement because:

- Wards across the hospital were not consistently clean, well equipped, well furnished, well maintained or fit for purpose. There were concerns around the cleanliness of patient areas, for example patient bathrooms. Some of the concerns impacted on patient dignity, such as broken privacy glass on Kirby ward and privacy film not being effective on bedroom windows.
- Most seclusion rooms were not en-suite and patients were regularly required to use bed pans while in seclusion, staff did not demonstrate that they supported patients' continence needs in a dignified manner while in seclusion.
- Environmental risks were not effectively managed as blind spots on four wards did not have measures in place to mitigate the risks; ward ligature risk assessments were not detailed and not all staff were aware of where ligature points were on the ward.
- Staff had not consistently managed clinic rooms effectively, some equipment in clinic rooms had not been recalibrated, Boston's clinic room was unclean and action had not been taken when the fridge was out of temperature range for 22 days over a two-month period.
- Patient autonomy was impacted by multiple blanket restrictions in place on wards. Staff did not apply individualised risk assessments to elements of patient care. The service's reducing restrictive practice group had not recognised some of the restrictions identified, had not appropriately assessed others and wards had failed to implement agreed actions for others.
- There were some administrative errors in patient's risk assessments, medicines cards, seclusion records and post rapid tranquilisation monitoring charts.
- The ward rotas were inconsistently allocated, and managers had not assigned safe staffing numbers or a nurse to some shifts. To manage this, managers shared their staffing resources and staff were regularly required to work on other wards within the hospital; impacting on skill mix and continuity for patients.

However:

Requires improvement



Summary of this inspection

- The service had enough medical and allied health professional staff, who knew the patients and received training to keep patients safe from avoidable harm. Staff routinely engaged in positive risk taking to facilitate patients' recovery and integration into the community.
- Staff had the skills required 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 and most wards had achieved a reduction in the use of restraint and seclusion.
- Staff had easy access to clinical information. Staff regularly reviewed the side effects of patients' medications.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The wards had a good track record on safety and the hospital managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and most contained a positive behavioural support plan.
- Staff provided a large range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives with dietary support and a range of exercise options.

Good



Summary of this inspection

- Staff supported and safeguarded staff and patients with protected characteristics and demonstrated a good knowledge of the Equality Act.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The wards included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. They supported each other to make sure patients had no gaps in their care, and engaged with them to inform patient care and plan discharge.
- Patients were supported to pursue a wide range of activities, education and vocational opportunities. Patients had jobs in the hospital and within the community and had access to an activity centre with animals, woodworking facilities and a music studio. Fenton ward also had specialised equipment to support patients' sensory needs.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and staff read patients' rights in a manner they could understand. A large proportion of patients had been allocated Section 17 leave.
- Staff demonstrated a good understanding of the Mental Capacity Act 2005 and appropriate capacity assessments were undertaken by the multidisciplinary team.

However:

- Although they had completed capacity assessments, this was not clearly recorded as staff did not know where capacity information was stored and were unable to provide evidence of best interests decisions. There was a lack of clear conditions documented in three patients' Section 17 leave paperwork.

Are services caring?

Our rating of this service stayed the same. We rated it as good because:

Good



Summary of this inspection

- Most patients reported that staff treated them with compassion and kindness and respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately and held well-received quarterly carers events, such as a Christmas meal and patient-run pantomime.

However:

- Some patients reported that staff could cross boundaries and come across as having "an attitude". Three patients reported that staff did not always knock before entering their bedrooms.

Are services responsive?

Our rating of this service stayed the same. We rated it as good because:

- Staff planned and managed admissions and discharges well. They liaised well with other services and were effective in managing care pathways for patients who were making the transition to or from another inpatient service or to prison.
- Patients on five wards had their own bedroom with an en-suite bathroom and all patients could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- We received multiple complaints regarding the quality and quantity of food provided. Not all patients could make hot drinks and access snacks at any time.
- The design, layout, and furnishings of some wards did not support patients' treatment, privacy and dignity.

Good



Are services well-led?

Our rating of this service stayed the same. We rated it as requires improvement because:

Requires improvement



Summary of this inspection

- Staff on Dalby ward reported that they did not always feel supported by the ward managers and some Boston staff said frequent changes in ward management had impacted on staff's sense of value. Staff reported that they did not feel valued by Priory group.
- The hospital's auditing processes had not effectively addressed errors and omissions in patient documentation, including capacity assessments, seclusion documentation, medicines cards, Section 17 leave records and physical health monitoring.
- The quality assurance processes did not provide sufficient oversight and had not been implemented effectively to ensure consistency in care standards across the hospital. Not all staff were familiar with ward ligature points; staff moves between wards were not always documented; meeting decisions, such as the reducing restrictive practice group's actions, had not been applied; and meetings were cancelled.

However:

- Most leaders across the hospital had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Most staff felt respected, supported and valued by their peers, their managers and the hospital. The hospital supported staff to gain additional qualifications and learning, such as health care support workers becoming nurses and the head of psychology travelling to San Francisco for radically open dialectical behavioural therapy training.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of repercussion.
- Staff engaged actively in local and national quality improvement activities and Fenton ward was the first medical facility in the country to achieve advanced accreditation by the Autism Accreditation Award Committee.

Detailed findings from this inspection

Mental Health Act responsibilities

Mandatory training in the Mental Health Act had been completed by 91% of staff, and staff spoken with during inspection could describe the Code of Practice guiding principles. Staff had easy access to the provider's policies and procedures on the Act. The hospital had Mental Health Act administrators and staff were able to access support and advice on implementing the Act and its Code of Practice.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, taking into account their communication needs, repeated as necessary and recorded this clearly within patients' notes.

The wards had weekly access to a general advocate and easy access to independent mental health advocacy; patients who lacked capacity were automatically referred to the service. Patients were documented to have been supported to take part in tribunals and challenge their detention status. Staff requested an opinion from a Second Opinion Appointed Doctor when required to and recorded this within patient Mental Health Act documentation.

Staff made sure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and with the Ministry of Justice when applicable. However, of the 20 care records reviewed, three had unclear terms within patients' Section 17 leave form. One stated a list of locations that the patient was permitted to visit followed by "etc"; two did not have any time restriction on the patients' escorted leave within the community.

The hospital audited compliance with the Mental Health Act during monthly quality walk rounds. A local pharmacy produced weekly audits of patient medicine cards to ensure they complied with the Act. Managers also conducted annual Mental Health Act audits.

The hospital did not have any informal patients within the hospital and did not accept informal patient referrals. Patients that were coming to the end of their section or looking to become informal were supported towards discharge to a more appropriate setting.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff spoken with during inspection demonstrated a good understanding of the Act and the five statutory principles. Mandatory training in the Mental Capacity Act had been completed by 89% of the workforce in this service. Staff had easy access to the provider's policies and guidance on the Mental Capacity Act and deprivation of liberty safeguards.

No patients had been cared for at the service under a Deprivation of Liberty Safeguard in the 12 months prior to inspection. Staff stated that patients were always assumed to have capacity, that patients were supported to make decisions themselves and that capacity was assessed on a decision specific basis as a multidisciplinary team. When a patient was deemed to lack capacity, we were told a best interests meeting

would be held and staff would take into account the patient's wishes, feelings, culture and history. The hospital always referred patients who lack capacity to an independent mental health advocacy service and liaised with their solicitor if applicable.

The service reported that they audited ward compliance with the Mental Capacity Act and conducted monthly quality walk rounds, compliance was then discussed within clinical governance meetings. However, ward staff were not aware where capacity documentation was kept. Staff said that capacity was assessed within patient ward rounds, and we were informed that patients' capacity would be documented within their independent care review notes. However, capacity was not consistently recorded in the minutes of every meeting. Patients who

Detailed findings from this inspection

had specific capacity concerns, such as around finances, did not have a clear record of best interests meetings or ongoing capacity assessments, and the reference to patient capacity had limited information. For example,






one stated that they lacked capacity to manage their finances and had a listed power of attorney, but staff were not able to show us a record of the capacity assessment or best interests decisions.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Forensic inpatient or secure wards

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

Are forensic inpatient or secure wards safe?

Requires improvement 

Safe and clean environment

One ward, Farndale, provided treatment to female patients, all other wards were for male patients only. All patients had their own bedroom, and patients on all wards except Boston and Kirby had en-suite shower facilities.

Staff could not observe all parts of the wards. Four of the wards had areas that were not visible from the main corridor and were not covered by mirrors. We were informed by staff that this was mitigated by the member of staff conducting observations and they remained in communal areas at all times. Staff also informed us that they would place higher risk patients in bedrooms away from those areas and closer to the nurses' office. Staff on Fenton ward informed us that when they had had instances of incidents occurring in the less visible area of the ward, they had allocated a member of staff to be stationed at that end of the corridor. Some patients reported that they would feel safer if there was closed circuit television in communal areas, as there was in the courtyard. They had also raised this with the service within the reducing restrictive practice group and they were informed that it would be fitted as part of the refurbishment works within the hospital.

There were potential ligature anchor points on all wards within this service (a ligature point is a place to which patients intent on self-harm might tie something to strangle themselves). All of the wards had had a ligature

risk assessment within the last 12 months, there was also a separate ligature risk assessment for the outside areas. Ligature risk assessments highlighted areas of the ward with reduced visibility as well as potential anchor points. The wards also had ligature maps within staff offices to identify which areas were of risk. However, not all staff were familiar with the information on the ligature risk assessments and were not able to tell us what the mitigation was for certain items, such as light fixtures and curtain rails. One staff member reported that the ward did not have any ligature points. Some of the information within the ligature risk assessments was also vague, for example stating "risk reduction feature" without stating what this was.

All staff were allocated a personal alarm before entering the hospital grounds. At the last inspection the service did not have a nurse call system for patients; this had been rectified at the time of this inspection and all patient bedrooms had been fitted with nurse call alarms. There was evidence of utilising their alarms being included in patients' care plans and patients reported that they had used their alarms for assistance.

Staff were observed to follow the provider's infection control policy, including handwashing, and 91% of staff had completed mandatory training in infection control. However, the ward environments were not consistently compliant with infection control principles. We were informed by domestic staff that their responsibilities had increased, that they felt "rushed" and they were not always able to do a "good enough job". At least one patient on each ward raised concerns around the cleanliness of the wards and the bathroom facilities. Particular concerns were raised regarding the cleanliness of bathrooms and toilets on Boston and Kirby wards. There was a mal odour on

Forensic inpatient or secure wards

Kirby ward and in the Boston seclusion bathroom, which was visibly unclean. Four showers on Boston ward had evidence of mould, as did two on Kirby ward, which had an additional shower room that was out of order. This concern has also been raised during Mental Health Act Reviewer visits. Staff informed us that they had tried to maintain it, but as they had been anticipating the new ward environment to be built, they had been attempting on-going maintenance of the concern, painting the showers regularly. Boston and Kirby were 24-bed wards and the only wards in which not all patients had en-suite facilities. Four rooms were en-suite, the remaining patients shared 12 toilets, four shower rooms and a bathroom, though on both wards half of the toilets were locked.

We had concerns about the suitability of the environment. We were informed that there was a privacy film on patient bedroom windows to ensure that people were not able to see into patient bedrooms from the courtyard; however, this was explored while inspecting three of the wards and the bedrooms near the courtyard were visible through the windows. Most doors to patient bedrooms had glass that could be opened and closed to allow observation when patients were in their bedrooms; some doors on Kirby ward had curtains in place of privacy glass. Not all wards had glass that allowed patients to open and close the windows from the inside, they were operated by staff, and some windows had been left in the open position during ward tours. Some window panes were also broken in a half open position on Kirby ward.

Leaders within the hospital informed us in 2016 that they had an extensive building project planned. The proposed works included renovations of the current ward environments, creating four 12-bed wards in place of Kirby and Boston (both 24-bed wards) and producing more spaces for one to one interventions and visitors rooms. At the time of inspection, the enabling works had commenced and new office spaces for multidisciplinary staff were being created, we were informed that the proposed date for completion was 2024. We were also informed that despite the building work, maintenance was still being conducted on both Boston and Kirby, such as a new dining room floor being laid on Boston. Maintenance work was listed in order of priority, with the highest level of priority being anything relating to health and safety, which

had a target to be managed within 2 hours and the lowest level of priority would be smaller concerns, such as a dripping tap, which the hospital would aim to respond to within the week.

However, there were concerns around maintenance and furnishing on the wards. For example, some of the décor and furnishings on Boston, Dalby, Fenton and Kirby appeared tired and there was some furniture on Hambleton, Fenton and Kirby wards that was not wipeable. There were broken or missing toilet seats on Hambleton, Fenton, Kirby and Boston wards. We had been told that replacements had been ordered, but staff informed us that it could take up to three weeks to receive a replacement. We were informed by patients that they had raised concerns regarding a broken door lock and a rotting shower door on Dalby, and that a broken light in a shower room on Kirby; but that these had not been addressed by the service. Patients described wards as “run down”, “old and rough” and “in need of modernisation” and some said that the chairs and beds were not comfortable. Concerns about furnishings and modernisation were not raised by patients on Farndale or Hambleton wards, who were happy with their ward environments. Staff and patients also informed us that patients had been unable to use their computer suite for three months as the wifi was not working. The hospital was aware of this issue and had raised it with Priory group without resolution.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Most wards had clean and tidy clinic rooms with updated cleaning rotas, daily fridge temperature checks and medicines cupboards were organised and appropriately stocked. However, there were inconsistencies in the infection control principles demonstrated in the ward clinic rooms. The clinic room on Boston ward appeared unclean, the floor and sink were visibly dirty and there were no cleaning stickers on equipment, we were informed on inspection that their cleaning record was not available. The medicines cupboard was untidy and disorganised, with several medicine boxes in a disposable vomit bowl. The fridge temperature had been recorded daily but was out of range on 15 days in December and seven days in January with no recorded action taken. The clinic room on Kirby ward was very small and had a lot of equipment in it, but it was clean and had visible cleaning records. However, the daily fridge temperature had not been completed on three days in

Forensic inpatient or secure wards

December and six days in January. Medicines with short expiry dates and liquid medicines did not have a recorded date of opening or a date to be discarded by. In addition, one blood pressure monitor on Farndale ward and one blood glucose monitor on Kirby ward were out of date in their maintenance checks.

All wards had two adjoining seclusion rooms, with the exception of Hambleton ward which did not have a seclusion room attached to the ward. We reviewed seven seclusion rooms during inspection. All allowed clear observation and two-way communication, all had the ability to control the temperature and the lighting and there was evidence in seclusion records that patients had used these functions. Wards has access to anti-ligature clothing and blankets and some patients had been care planned to use these when in seclusion. Patients could see a clock and the seclusion rooms on Boston and Kirby wards also had access to a television that was behind a Perspex pane. Seclusion rooms had access to a seclusion garden that patients could access if care planned.

Only one of the seclusion rooms in the hospital, one on Farndale ward, was en-suite; all of the other wards had a shower room within the locked seclusion area, but it was not accessible without staff assistance. Patients were given disposable bed pans and urine bottles to use in the seclusion room if they were unable to access the seclusion bathroom due to risk or staffing; patients reported that this impacted on their dignity. The seclusion area in Boston's seclusion area was unclean and had a mal odour, this was raised during inspection and staff requested for the domestic team to clean it that day. The seclusion room on Dalby had urine bottles and bed pans placed in the seclusion room prior to a patient being in there, pre-empting the use of them without individually assessing the patient. This has been raised as an area of concern previously following Mental Health Act reviewer visits to the wards.

Safe staffing

Between 01 August 2018 and 31 July 2019 the service had 102 staff leavers, resulting in 17.2% vacancy rate. On 24 October 2019 the service reported to have 23 outstanding nurse vacancies, this had reduced since the previous inspection, at which time there were 32. The service had 10 health care support worker vacancies, this had increased by one since the last inspection.

The hospital had been running robust recruitment and retention campaigns. They had supported staff through additional learning, such as supporting health care support workers to complete their nursing degree, allocated staff a £250 training budget for professional development and funded nurse's registration with the Nursing and Midwifery Council. They had also conducted assessment centre days, and had been selected for a pilot scheme within the Priory in conjunction with an overseas recruitment firm to explore the potential for hiring nurses from South Africa on a three-year contract.

Level of staff sickness was between 2.2% and 2.9% on all wards except Hambleton and Kyme, which had 4.4% and 4.5% respectively between 01 August 2018 and 31 July 2019. This was comparable to the sickness rate of 3.8% reported at the last inspection in date. Managers supported staff who needed time off for ill health. They were able to give recent examples of staff who had been supported to have phased returns to the ward environment, and given administrative tasks for a period of adjustment, as well as staff who had been offered internal transfers following serious incidents. However, some staff reported concerns that they would not be paid if they took sickness leave and would remain at work when unwell as a result.

Stockton Hall employed their own bank staff. They worked with agencies to block book staff to ensure continuity for the patients. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had relatively consistent use of bank and agency nurses. Between 01 July 2019 and 30 September 2019, 1,621 shifts were filled by bank staff and 222 were filled by agency staff in order to cover sickness, absence or vacancies as well as in response to increased need on the wards. The highest frequency of bank staff use was Kirby ward with 342 shifts filled, the lowest use was Farndale with 154 shifts filled. The highest use of agency staff was Farndale, with 125 shifts filled, while Boston was the lowest with 6 shifts filled. They reported that no shifts had remained unfilled. At the previous inspection, 1684 shifts had been covered by bank and 33 by agency.

Some staff reported that there was not always enough staff to respond to alarms and that the alarm would sometimes have to be raised on multiple occasions in order to get the correct number of responders. We raised this concern with staff at the security lodge. They informed us that all alarms

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were received by them, they then put the alert out to the wards and watched the service's closed circuit television to account for how many wards had responded, and make a record in the security log book if they need to raise the alert for a second time. The log book for December 2019 and January 2020 and there were no recorded incidents of the alarm being raised on more than one occasion. The hospital also ran regular drills, in which they called for assistance for a medical emergency and for incident support to audit staff responses.

Patients and staff reported that staff would endeavour to fulfil patient leave, where it was not possible, they would rearrange or reduce the time allocated rather than cancelling it. However, staff on Dalby and Boston ward reported that leave was cancelled as a result of staffing levels. Patients and staff reported that they had regular 1:1s, this was evidenced within patient records on Fenton and Hambleton. However, patient care records from other ward recorded this inconsistently and some patients had no record of any 1:1 interactions over a three month period. Some staff on Boston, Dalby and Kirby wards also reported that staffing levels did not always allow for staff to take breaks. This was disputed by managers who stated that staff were encouraged to take breaks and staff from other wards would attend the ward to facilitate this if needed.

Each ward had a health care assistant allocated to the ward on weekdays, who was supernumerary and was available to run activities with patients, facilitate leave, and to escort patients to therapies with members of the multidisciplinary team. Staff and patients on Dalby ward informed us that the frequency of Section 17 leave and patient 1:1s had decreased over the previous month as three patients were in seclusion and this had put a strain on staff resources.

At every morning meeting ward managers discussed the ward dynamics, any patients in seclusion, any patients on enhanced observations and their staffing levels and would share nurse and health care support worker allocation between wards in order to ensure safe staffing levels. Staff also reviewed staffing levels for the week ahead within this meeting. Most staff said that wards were safely staffed. However, staff reported during focus groups and interviews during inspection that transferring staff across wards sometimes impacted on quality of care and the skill mix on the wards. Staff also reported that it caused anxiety as they could feel that they were comfortably staffed and then

gradually lose staff to other wards over the course of the day. Some staff did speak of the benefits of having flexibility with resources, and stated that staff were willing to assist other wards and to support patients to facilitate activities.

We reviewed the rota information for all wards from 30 December 2019 until 31 January 2020. The rotas were inconsistent in their allocation. There were two occasions on Hambleton ward and one on Fenton when the ward had one member of staff allocated to a shift, yet five or six staff were allocated later in the week. There was no nurse allocated to 13 shifts on Dalby ward, four on Hambleton and four on Kirby ward; yet for the same date as some night shifts had no nurse allocated on Dalby, the day shift had four nurses assigned. However, as staff regularly utilised staff from other wards, the information listed was not reliable. For example, when Hambleton ward had just one staff member allocated to the night shift on 17 January 2020, Boston ward had eight staff allocated. While it would be reasonable to assume that staff from Boston supported Hambleton ward, this was not documented. We discussed this with senior management following inspection, they had inputted a table to record staffing changes, but this had not been routinely completed at the time of inspection.

The service had enough daytime and night time medical cover and a consultant was available to attend the wards quickly in an emergency. Kyme ward had their own consultant psychologist as well as support from the Fenton consultant psychiatrist, all other wards had one consultant psychiatrist allocated to them. The hospital did not have any junior doctors, though we were informed that this was under review. The hospital had overnight accommodation for consultant psychiatrists to stay in during the evenings and weekends, the consultants also provided cover for two other local hospitals.

The hospital consultants informed us that they arranged cover for annual leave and sickness from other consultants within the hospital, they did not use locum doctors or bank and agency support. It was reported that they would be able to cover the fundamental aspects of patient care but would not be able to do routine duties such as ward rounds.

All staff received a mandatory induction and completed a regular mandatory training programme that was comprehensive and met the needs of patients and staff. Compliance was reviewed at monthly governance

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meetings. The learning and development co-ordinator was responsible for providing the heads of departments with monthly training reports and planners to assist them in monitoring the compliance of the staff within their ward or department, and identified staff with training due for renewal within three months. Managers monitored this and alerted staff when they were required to do additional training.

The compliance for mandatory and statutory training courses in September 2019 was above 80% for all modules, with the exception of emergency first aid, which had a compliance figure of 56%. Basic life support training had been completed by 85% of staff applicable and immediate life support had been completed by 92% of staff applicable.

Ancillary staff reported that they would benefit from a greater understanding of mental health and additional training in conflict resolution, to better be able to respond if something were to happen when they were unattended.

Assessing and managing risk to patients and staff

We reviewed 20 patient care records. Staff had completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

There were some administrative errors in relation to the recording of risk information. There was lack of clarity within one care plan on Kirby, as the patient's risk had increased from no harm to low harm in nine categories when the patient's risk assessment had been reviewed but stated "no change". A Boston patient's risk management plan stated that they were "currently nursed in seclusion", but in the review section below discussed the patient using Section 17 leave and the music room. One patient on Dalby ward and outdated alert on their home page, which referenced the most recent serious incident as April, when it had occurred again in October. Another patient on Farndale ward had an alert on their home page that referenced a safeguarding incident that was not mentioned within the patient's risk assessment.

We reviewed 20 patients' keeping safe care plans, of these 18 included a positive behaviour support plan. The remaining two were for patients on Farndale ward who had a risk management plan in place and very personalised and holistic care plans. Patients' personal behaviour support plans included patient's warning signs, how to support the patient, their likes, dislikes and preferences in

the event of restraint being carried out. Interventions increased from verbal prompts and redirection to higher interventions such as use of restraint and entry into seclusion.

Positive behaviour support planning was mandatory training for some staff and 95% of staff eligible had completed this. The plans reviewed were very personalised and included information such as music they found helpful, items they would like to be removed from their possession and how they would like to be approached by staff.

Staff identified and responded to any changes in risks to, or posed by, patients as detailed within their personal behaviour support plans. Staff were able to describe certain warning signs for individuals and their preferred management strategies when asked. There was an incident of restraint on Farndale while we were at the hospital when staff had not followed the patient's preferred method of restraint as male staff had held her arms, not female staff. When asked why this had happened, we were informed it was due to the violent nature of the incident, and because the patient's preference is to look at a familiar female, so the female staff offered verbal de-escalation and faced the patient. They informed us that they had used low level holds for as minimal time as possible.

There had been a serious incident on Dalby ward the month prior to inspection. Staff and patients reported that they had been aware that risk was increasing and had raised this with ward management but no further action had been taken. The hospital was investigating the incident at the time of inspection.

Staff described a collaborative approach to managing risk on the wards, stating that staff worked with patients to take therapeutic risks and develop mutual trust. The hospital had a high number of patients with Section 17 leave, for example, all except one patient had been written up for Section 17 leave on Farndale ward.

Staff took a multidisciplinary approach to risk assessment and risk management. For example, psychology staff were involved in patient's positive behaviour support plans and HCR20s; and occupational therapists conducted individual risk assessments for patients accessing activities and any proposed new activities were discussed within security meetings.

The hospital had clear security protocols in place. The hospital's security lodge was staffed 24 hours a day. The

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hospital had a tall perimeter fence, closed circuit television covering outside areas and an air lock to enter and exit the hospital grounds. Security staff conducted two perimeter checks daily to remain vigilant to security breaches or any contraband items. The hospital had a list of prohibited items; such as mobile phones, vapes and sharps; this was applicable to all patients, staff and visitors. Staff were not allocated keys unless they had the correct belt and pouch on their person. All staff were given personal alarms and multidisciplinary staff were provided with radios if they were lone working; though domestic staff said this provision was not available to them. Staff informed us that visiting professionals would also be given an alarm, although we were informed by an external visitor this had not happened on one occasion. Each shift a member of staff was allocated to be security coordinator for their ward and had specific tasks they were required to complete that day, such as counting the cutlery and any maintenance staff's tools if they were on the ward.

Staff followed trust policies and procedures when conducting searches of patients or their bedrooms to keep them safe from harm. We were informed that all patients were searched on their return from unescorted leave and that staff utilised a randomiser to ascertain whether they would be searched following escorted leave. The hospital had reduced the frequency of bedroom searches in response to the reducing restrictive practice group; however, patients had stated that they did not like the change, so staff returned to conducting random monthly checks in response.

This service had 122 incidences of restraint involving 28 different patients between 01 February 2019 and 31 July 2019; of these three resulted in the use of prone restraint (all of which occurred on Boston ward in response to the patient moving to the floor). During the same period the hospital reported 64 incidences of seclusion and no incidences of long-term segregation. The ward with the highest frequency of seclusion was Boston ward which recorded 27; Farndale, Fenton and Kirby all recorded 12; Dalby recorded 1 and there were no instances for Hambleton or Kyme wards.

All of the wards reported a reduction in the use of restraint and seclusion when compared to the same period the previous year, with the exception of Farndale ward. Farndale's restraint figures had increased from eight to 76, and seclusions had increased from seven to 12. They

reported that this was the result of one admission. Fenton had reported the greatest reduction, their restraint figures had reduced from 30 to six, and seclusion had reduced from 34 to 12. There had been an increase in the use of seclusion within the hospital at the time of inspection and six patients had been secluded following incidents over the festive period.

Staff participated in the provider's restrictive interventions reduction programme and had a restraint reduction network. The hospital had integrated Safe Wards principles, such as de-escalation techniques which included the use of 'soft words', into staff's management of violence and aggression training. The training had also been amended to remove the use of prone and supine restraint. The hospital had invested in large bean bags to use as an aid during de-escalation. Patients reported to find these useful, they had been placed in some ward de-escalation areas and one patient had requested the use of one in seclusion. Staff reported that they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients who informed us that they had been restrained confirmed this assertion.

We reviewed three post rapid tranquilisation monitoring forms during inspection. Two from Farndale ward and one from Boston, we were informed that none of the other wards had used rapid tranquilisation in the three months prior to inspection. At all time intervals, except one instance when physical observations were taken, staff had written "declined". Staff did not note respirations but did note sedation score and extra pyramidal side effects score. However, the two forms for Farndale ward recorded the extra-pyramidal side effect score as "3 – severe" for all intervals, with no explanation or description as to what this was and why it did not warrant additional monitoring.

We reviewed seven seclusion records during inspection and found there to be errors in documentation. Two patients did not have a recorded plan to exit seclusion, we were informed this was because the hospital had made a clinical decision that they could not manage the patients' risk and they had both been referred to alternative hospitals; however, this was contrary to best practice guidelines. A patient informed us that they had not had their bed pan removed at regular intervals and they had eaten their meal with a used bed pan in the room. Staff reported that this would not occur as staff would have to enter the room in

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order to provide the meal so would remove the bed pan at that time. However, patient seclusion records were not consistently clear when patients' bedpans had been removed. One record did not specify that a bed pan had been removed after it had been recorded as used for an 8-hour period, another did not specify it had been removed for a period of four hours. Additionally, there were two references within seclusion records that stated patients had not been supported to access the seclusion room toilet due to staffing restrictions. Records were also not always clear in 15-minute notes when patients had accessed a shower or eaten. One record also did not specify what items the patient had taken into seclusion with them and two patients did not have an independent MDT review within 12 hours.

Records did, however, demonstrate that a patient on Farndale had been given access to the seclusion garden, that patients had regular access to multidisciplinary staff and contacts of their choosing, including solicitors and independent advocates; that patients had partaken in activities such as listening to the radio and playing cards; and that staff had enabled regular phone contact with relatives and carers.

We also attended two seclusion reviews on Farndale during inspection. Staff discussed risk management and had a handover from staff prior to going in to see the patients. The consultant led the discussions and approached patients in a kind and respectful way, crouching to their level while talking to them. The social worker also asked patients whether they would like their families to be provided with an update.

The service had multiple blanket restrictions in place at the time of inspection. Examples included: patients were limited to three trips to the hospital's shop / café per week; bedroom corridors were locked during meal times and medication rounds, this meant that patients were required to be up and out of their beds in time for their morning medication and breakfast time; patients on Farndale and Kyme wards informed us that they were requested to return to their bedrooms at 11pm Sunday to Thursday and 1am Friday and Saturday, staff informed us that this was encouraged to support patients' sleep hygiene; staff and patients said that unescorted patients were able to access the courtyard four times a day for 30 minute intervals and escorted patients were able to access the courtyard four times a day for 15 minute intervals.

The reducing restrictive practice group had discussed some of the blanket restrictions we found to be in place. However, the reducing restrictive practice log did not always provide an appropriate reason as to why the restriction applied, or wards were still implementing it as a rule despite it being agreed within the meeting to be removed. For example, patients' access to the outside areas was restricted to daylight hours, at the time of inspection patients were not able to access them past 4pm, this increased at set increments as daylight hours increased. This had been raised during reducing restrictive practice meetings, the decision recorded on 10 August 2018 was "extended ward garden access was agreed, this will be at the discretion of the nurse in charge who will determine the number of staff required to facilitate (minimum 1). All access will finish by dusk, in winter the access will finish at the same time as the courtyard leave." However, this does not explain why all patients need to be escorted or why any outside access can't be facilitated past daylight hours. Another example is the side rooms (pool room, activity areas) being locked on wards, it was agreed on 21 March 2019 that these rooms would no longer be locked. However, at the time of inspection, Dalby, Kyme and Farndale had locked pool rooms and Kyme also had a locked activity room.

The hospital had introduced personal mobile phones for patients, with calling and texting functions, as part of their programme of reducing restrictive practices. They had introduced the phones with a series of restrictions. For example, patients were required to hand their phones into the office at 11pm Sunday to Thursday and at 1am on Fridays and Saturdays and patients had been asked to make phone calls and send texts in their bedrooms. The introduction of mobile phones was still in a trial period at the time of inspection and the provider informed us that following a review involving patients and staff, the time restriction on patient access to their phones had been removed.

Safeguarding

Staff knew how to make a safeguarding referral and who to inform if they had concerns. (A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional. Each authority

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has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.)

Staff received training on how to recognise and report abuse, appropriate for their role. In September 2019, 94% of staff had completed both safeguarding adults and safeguarding children training and 87% of staff had completed face to face combined safeguarding training. Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Incidents were assessed for referral in accordance with the local authority's threshold for reporting incidents.

Wards held regular patient safety meetings to discuss any safeguarding concerns for patients. Staff approached this with a multidisciplinary team and included the safeguarding lead for the hospital. Patients who were involved in the safeguarding were invited to attend to discuss their concerns and give their opinions. Alleged perpetrators were also invited to attend meetings where applicable. Those in attendance would then agree a plan of how to safeguard the patient.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Safeguarding was discussed each week day during the morning meeting. The morning meeting we attended during inspection was attended by 16 senior members of staff including ward managers, the medical director, social worker lead and security staff.

All wards had a designated safeguarding lead. The director of clinical services was the safeguarding lead for the hospital and had developed strong links with the local safeguarding structures. They produced a monthly report which was discussed within clinical governance meetings and produced a quarterly report that was sent to the local authority, identifying themes in safeguarding referrals as well as safeguarding concerns that had not met the threshold for referral. The safeguarding lead sat on the safeguarding board and the lessons learnt board for the

local council, and acted as the regional safeguarding cluster lead for the Priory group. The hospital was also approached for advice from the police regarding how to respond to sensitive safeguarding concerns.

Staff followed clear procedures to keep children visiting the hospital safe. They did not have access to the ward areas, visits took place in the Galtres centre.

Staff access to essential information

Patient records were kept electronically and were stored securely to maintain data confidentiality. Patient records were easy to access and staff had individual log ins. Patient care record main pages had essential information on, with alerts such as high-risk incidents and patient allergy information. Staff kept risk assessments, care plans, Mental Health Act paperwork and daily notes in consistent sections of the software across wards, making it easy for staff to navigate if they were providing care on a different ward. When patients transferred to a new team, there were no delays in staff accessing their records, staff received patient information prior to admission and shared it with the new provider prior to discharge.

However, not all information within patient care records was up to date. For example, an alert on a patient's home page stated that they had had a serious incident of self-harm in April; however, the patient had had another serious incident in October and this was not reflected in the alert.

There was also very inconsistent quality in staff's recording of patients' daily interventions. Some lacked detail and gave no indication of patient presentation, interaction with other or any activities they had been involved in. For example, one said: "Spent day between ward and bedroom. Interacted with staff and peers throughout the day. Has attended ward for meal and meds time. No incident to report", that is all that was written to document a patient's presentation risk and interaction with staff over a 12-hour period. This inconsistency was particularly pertinent for multidisciplinary staff who reviewed patient daily notes as part of their preparation prior to carrying out therapeutic interventions with patients.

Medicines management

Each ward had a consultant psychiatrist attached who took the lead in medicines management on the ward. Consultants took part in peer reviews and conducted

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assessments of prescribing and medicines management on other wards. The medical director took the lead in medicines management for the hospital. The service had also trained two staff as non-medical prescribers. They had trained 11 nurses in total but the others had since left the service.

The service linked with a local pharmacy who visited the wards weekly. They conducted medicines management audits. The service produced incident reports for medication errors and concerns around medicines management. The hospital was conducting an investigation at the time of inspection as a medicines liable to misuse unaccounted for. Where staff members had been noted to make medicines errors, they were provided with additional supervision and support.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines and about side effects of medicine. There was evidence within care records of patients' stating their preferences to use or omit particular medications, and these had been accepted. A patient on Farndale had been given a new medicine while in seclusion, we attended their seclusion review during inspection. The consultant asked her about how she was feeling physically and mentally, asked questions relating to potential side effects, explained the ongoing medicine management plan and asked if she agreed with this, offering the opportunity to ask any questions.

Staff followed current national practice to check patients had the correct medicines. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We found that most prescribing was within the British National Formulary prescribing limits; where it exceeded limits regular high dose antipsychotic therapy checks were carried out, with the exception of one patient on Kyme ward who did not have an appropriate care plan in place to manage this. This was raised during inspection.

The service did not routinely treat patients' mental health with medicine and we reviewed three medicines cards for patients within the hospital who did not receive any mental health medication and were instead treated with therapeutic interventions.

Most staff stored and managed medicines and prescribing documents in line with the provider's policy. However, 12 of

the 66 medicines cards reviewed had at least one missing signature. Kirby ward had open medicines that were all in use at the time of inspection (including liquid lorazepam, E45, Gaviscon, diazepam, denzapine nasal spray and four salbutamol inhalers) with no stickers on for date of opening. The medicines cupboard on Boston was also untidy and disorganised, and the fridge temperature was recorded as out of range on 15 days in December 2019 and seven days in January 2020 with no recorded action taken.

Staff were aware of the requirements of physical health monitoring and were able to describe what physical health monitoring was needed for individual patients, as described within patient care plans, when asked. However, of the 20 care records reviewed, five did not have physical observations recorded in line with the patient's physical health care plan, for example, one patient's blood sugar had not been monitored daily, another patient did not have their blood results documented at the required intervals.

Track record on safety

Between 01 January 2019 and 01 August 2019 there were five serious incidents reported by this service. Of the total number of incidents reported, three were incidents of serious self-harm on Dalby ward, one was an attempted absconson by a patient on Kyme and one was a Boston patient who did not return from unescorted leave. All of these incidents were responded to with changes to the individuals' risk management plans. The number of serious incidents reported during this inspection was lower than the 10 reported at the last inspection.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, serious incidents, and near misses in line with the provider policy. The service had no never events on any wards. Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. However, a member of staff reported that staff did not always log when patient property went missing.

All incidents were reviewed on a daily basis at the morning meeting and within the hospital and ward clinical governance meetings. Serious untoward incidents were subject to a situation, background, assessment and

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recommendations investigation by a member of the senior management team or an external investigator, managers were required to undertake training prior to undertaking an investigation. Patients and their families were involved in these investigations where possible and applicable. Investigations were a standing agenda item in monthly operations meetings and clinical governance meetings and lessons learnt are disseminated. For example, there had been a fault with the nurse call system and the alarm had not sounded when a patient had pressed it for support. The hospital introduced a new system to boost the alarm's signal as well as weekly checks to ensure it is functioning correctly; this learning was shared with other hospitals within the Priory group.

The service also held monthly lessons learnt meetings and shared lessons learnt for smaller incident between wards. For example, other ward staff were aware that the large de-escalation beanbags could be opened and the filling removed, following an incident on Farndale ward. The ward manager for Farndale had also notified the company that produced the product that this had happened.

Most staff informed us that they received debriefs and support following serious incidents. Staff had access to an anonymous support hotline. Following a recent serious incident, staff had received individual support over the phone and group support face to face using this service. Staff were also provided with support from the hospital psychologists following serious incidents. Senior managers also reviewed trends in incidents to identify whether any staff member might need additional support. For example, following racial or physical abuse.

Staff informed us of an incident of violence between staff members in a communal area of a ward. We were informed by the ward manager that the incident was discussed within team meetings and supervision. However, the incident was not discussed with patients who were present, we were informed this was because none had indicated that they had been aware of it happening.

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 patient care. There was evidence that changes had been made as a result of feedback. For example, following a serious incident on Farndale ward, counting the tools brought onto and off the ward by maintenance staff was added to the

duties of the security officer for that shift. Managers shared learning with their staff about never events that happened elsewhere, such as following ligature incidents in other secure environments.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good



Assessment of needs and planning of care

We reviewed 20 patient care records during inspection. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients 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 patient that met their mental and physical health needs and all care records were holistic, recovery orientated and showed evidence of personalised content and patient involvement. Patient care plans were split into different headings: keeping well, keeping safe, keeping connected and keeping healthy, with different sub heading for patients as applicable; for example, keeping healthy: diabetes management.

Most patients' keeping safe care plan included a personalised positive behaviour support plan with information including patient's warning signs, how to support the patient, their likes, dislikes and preferences in the event of restraint being carried out.

Care records took account of a holistic range of patient needs; including their communication, religion and vocational requirements. There was also evidence within care plans for patients on Farndale, Dalby, Kyme and Fenton ward of patients' sexual needs being taken into account. Patients were supported to have items to respond to their sexual needs, this was carefully care planned and staff had been spoken to with regards to managing this. The psychology department had also conducted a research project looking into staff responses to patients' sexualised behaviours.

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However, there was inconsistent recording of discharge planning. We were told by some staff that this would be discussed in the social care section of patient's care records, and by other staff that it would be in their independent care review minutes, neither was consistently the case and some patients had no record of discharge planning evident. When talking to patients, even patients newly admitted into the service, it was evident that patients and staff regularly engaged in discussions surrounding discharge and the steps required for them to achieve this, this was not documented effectively within patient files.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service and delivered care in line with best practice and national guidance. Patients had access to dialectical behavioural therapy, radically open dialectical behavioural therapy, cognitive behavioural therapy, mindfulness, the model of human occupation behavioural framework and substance misuse support. Wards developed specific programmes for their patient group, such as Dalby ward, which had introduced stop and think groups. They also received individualised support surrounding their index offences if applicable, for example, if patients had committed arson.

Staff identified patients' physical health needs and recorded them in their care plans and staff made sure patients had access to physical health care. The hospital employed two full time practice nurses, who were also available to contact out of hours for support. They had regular involvement with patients and supported ward staff in additional training, such as wound care and stoma care for staff on Hambleton ward. A GP visited wards twice a week and a dentist visited weekly. Patients also had twice monthly access to a speech and language therapist. There was evidence within patient care records of patients accessing specialist physical health care as required. For example, patients had support from chiropody, a diabetes clinic and physiotherapy.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The hospital was engaged within the NHS Commissioning for Quality and Innovation framework for maintaining healthy weight in a secure environment. They had introduced healthy eating initiatives, including monthly health eating groups, and the dietician had joined with the kitchen staff to review the menu options. Options provided by the

hospital's shop / café were being reviewed and some of the unhealthy options were being replaced with healthy or non-food items, such as physical health trackers. The dietician was shared across all wards so was available to meet with patients on a consultancy basis, or if there was an urgent need, but not to provide regular dietary support. The dietician had worked alongside the occupational therapists to support them in creating healthy activity choices for patients, such as healthy cooking sessions. They had also produced specific information guidance to give to staff and patients on portion sizes, reducing sugar and recommended portioning for different food groups. They had also produced guidance for carers on healthy food and snacks that they could consider bringing in for patients. However, some of the healthy eating initiatives had become blanket restrictions, for example, the hospital had introduced restrictions on the number of snacks and fizzy drinks patients were able to buy from the shop.

The hospital had a gym, which had recently been refurbished. Staff and patients were able to influence the design of the gym floor to incorporate multiple different sports. The gym staff had created different fitness programmes for patients, both individually and in open classes for up to 20 patients, to assist them in increasing their fitness levels; they also ran female only sessions. Examples of activities included: spin, cricket, baseball, basketball, badminton, table tennis, and indoor football, which was an activity that patients spoke particularly highly of. They ran a bootcamp group in the mornings for patients to attend and then make a healthy alternative breakfast in the Galtres centre. The gym instructors had created activity programmes for patients who were in seclusion. We observed ongoing gym sessions during inspection and patients appeared confident and familiar with their exercise programmes; they reported to enjoy the gym and felt it had been beneficial to their recovery. Health care support workers had been trained to use the sports hall, so patients could access this area when the gym instructors weren't present.

The hospital also engaged in activities that encouraged patients to lead healthier lives as well as supporting their integration with the community. For example, they held village walks in which patients, staff and local residents walked around Stockton village; and took part in a local football league in which patients played against other hospitals.

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Staff used a range of recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. All patients had at least a Historical Clinical Management_20 and Health of the Nation Outcome Scales within their care records, with the exception of one patient who was on trial leave from a high secure placement. There were multiple other outcome tools within patient files, including luners assessments, lester tools, and collaborative physical health assessments.

There was some outstanding and creative means of utilising technology to support patients on Fenton ward. The ward had a separate sensory room with bean bags, light tubes, a trampoline, music, projections of the solar system, and a sensory game on the wall to assist patients with their responses. There was a separate padded room that patients could access to de-escalate, de-stress, or relax in, with padded furniture, bean bags, and padded items. Staff had signs, leaflets and community meeting minutes in easy read format and patient care records were also given to them in an easy read format if required.

The hospital had an activity hub called the Galtres centre. Patients had access to music room and recording studio; wood workshop; animals including a budgie, fish and guinea pigs; a shop/café run by patients; rehabilitation kitchens; art facilities and a gym. There was also a computer suite within the Galtres centre to allow patients to be able to access the internet, though this was out of order due to a wifi issue at the time of inspection.

Patient activities included bingo, horticulture, quizzes, games console tournaments, pool and movie nights facilitated by the hospital's dvd library. Farndale ward held pamper evenings. The wards also facilitated trips into the community, including to go bowling, to the cinema, the Viking centre and trips to the seaside. Patients reported that the weekends were "boring" as the Galtres was shut and the majority of the multidisciplinary team were not available to do activities. The hospital did provide activities on the weekends, such as football tournaments and ward-based activities such as board games.

We observed an activity conducted by the hospital's drama teacher with a patient from Fenton ward. The patient completed a movement session with breathing exercises, then they gave the patient choices on what activity they

wished to do that day and incorporated tasks that encouraged the patients' speech. The teacher was encouraging and kind, and the patient appeared to be engaged and happy throughout.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The hospital conducted annual audits of infection prevention and control, Mental Health Act, safeguarding and clinical supervision; they conducted biannual ligature audits. Managers discussed results from audits within clinical governance meetings to make improvements. They were subject to internal monitoring inspections that followed a similar structure to the CQC inspections, producing recommendations for improvement and conducting follow up visits to assess whether these had been implemented. The hospital also took part in the Quality Network for Forensic Mental Health Services annual quality peer review, which provided the opportunity to compare the service to other secure hospitals and share examples of best practice.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the wards. Each ward had a designated occupational therapist and psychologist and each ward had part time social worker cover. The hospital also employed two practice nurses, a dietician, assistant psychologists, technical instructors, a drama teacher and gym instructors. A GP, dentist, pharmacist, chaplain, imam and independent general advocate also visited the hospital once or twice weekly; a speech and language therapist visited the hospital twice a month.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. They followed a Priory policy on safer recruitment and selection. All new staff members were given a three-week induction to the service before they started work, new starters were required to undertake a period of shadowing and to complete a competency checklist that was signed off by their ward manager.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. On 30 September 2019 all wards had achieved an overall appraisal rate for non-medical staff of 91% or

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higher, with the exception of Boston ward which had achieved 77%. All doctors had achieved their revalidation, they reported to us that they received supervision from the clinical director on an individual and group basis.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Clinical supervision came in different forms within the hospital, including group supervision and reflective practice. Staff informed us that they received supervision regularly and had a period of increased supervision during their induction or when requested. The provider's target of clinical supervision for ward staff is 85% of the sessions required, for the months of September 2019 all wards had achieved between 86% and 100% compliance.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had access to mental health awareness training as well as wards specific training that was tailored to the needs of their client groups. For example, as part of their induction, Fenton staff were required to complete training in understanding autism, staff on Dalby and Farndale wards had been trained in dialectical behavioural therapy. However, staff on Kyme ward had not had learning disability specific training and Farndale staff reported that they had not received personality disorder training. We were informed by managers that additional training could be requested through clinical governance meetings.

Ward staff had the opportunity to attend away days to discuss the needs of the patients on their wards, such as learning disabilities and personality disorders, and review their knowledge. The service had newly introduced mental health awareness groups for ward staff to attend for staff to improve their knowledge. Managers made sure staff attended regular team meetings and minutes were available for staff that had been unable to attend.

Managers recognised poor performance, could identify the reasons and dealt with these. The service investigated concerns regarding staff conduct and performance, suspending staff pending investigation where necessary and producing performance improvement plans. One staff member was dismissed from role following a disciplinary hearing in the six months prior to inspection. However, some staff members reported that they did not feel that strong enough action was always taken in response to

incidents of staff behaviour. We explored the example we were given with the ward manager and we were informed that the matter had been investigated and the staff member had been subject to disciplinary actions.

Multi-disciplinary and inter-agency team work

All ward staff for the upcoming shift attended a handover meeting. Each patient was discussed and staff were notified of any changes in patient presentation. Multidisciplinary staff received a separate handover, reviewed patient entries and spoke to the ward staff about patient presentation prior to engaging in activities. Managers from different professional disciplines, such as the head of psychology and the medical director, also attended a morning meeting on weekdays to discuss topics such as admissions and discharges, incidents, safeguarding concerns, review the progression of any seclusion, and changes to patient observation.

Ward teams had effective working relationships with other teams in the organisation and worked collaboratively towards patient care. Multidisciplinary staff during the focus groups and inspection informed us that communication between the ward staff and allied health professionals was very strong. Staff from different wards supported each other during incidents and staff regularly worked on different wards to cover when they were short staffed. Staff held regular multidisciplinary meetings to discuss patients and improve their care and wards held formulation meetings weekly, to discuss patients as a multidisciplinary team and gain a deeper understanding of patients' history and risks. All care records reviewed evidenced that patients had regular involvement with staff from multiple disciplines, according to their care needs. Staff shared learning and training across disciplines; for example, the occupational therapist for Fenton ward conducted sensory integration training and the psychologist on Dalby ward provided boundaries training for ward staff.

Multidisciplinary team staff informed us that they often struggled with filling all vacancies and reported that workload was not distributed equitably due to the difference in the number of patients on wards (i.e. an 8-bed ward compared to a 24-bed ward). We were informed that the hospital had had difficulty in filling psychologist positions and that there was one outstanding vacancy for a social worker and an occupational therapist. Staff informed us that this meant they were required to focus on the high

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priority tasks, such as safeguarding and tribunals, and therapeutic elements could be postponed or cancelled. We were told that the impact of this was felt more acutely in the occupational therapy department following the hospital's acquisition by the Priory Group. Staff reported that the occupational therapy assistant role was removed and the role of activity nurse was created in its place. Activity nurses were health care support workers who were supernumerary to support with activities on the wards. However, we were informed that it was often a different staff member assigned which removed continuity for patients and meant that in the case of an occupational therapist being on leave, unwell, or pregnant and therefore office based, patients' occupational therapy activities were suspended.

Ward teams had effective working relationships with external teams and organisations. Social workers took the lead in gathering probation information, patients' forensic histories and Multi-Agency Public Protection Arrangement information. They liaised with the necessary external agencies to support patients with their housing and benefits. Staff had developed strong links with local safeguarding structures and physical health services.

Adherence to the MHA and the MHA Code of Practice

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. As of September 2019, 91% of staff had completed mandatory training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. 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. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The wards had weekly access to a general advocate, and patients met with them regularly. During recent Mental Health Act Review visits, concerns had been raised as patients were not being referred to an independent Mental

Health Advocate. The service had since linked with a mental health advocacy service and information regarding access to this was available on wards and there was evidence of patients accessing this service. Patients were documented to have been supported to take part in tribunals and challenge their detention status. Staff requested an opinion from a Second Opinion Appointed Doctor when required to and recorded this within patient Mental Health Act documentation.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. There was evidence within patient records of staff utilising interpreters to assist if English was not the patient's preferred language; or repeating the patient's rights later the same week if there was concerns regarding fluctuating capacity.

Staff made sure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice when applicable. However, of the 20 care records reviewed, three had unclear terms within the patients' Section 17 leave forms. One stated a list of locations that the patient was permitted to visit followed by "etc"; two did not have any time restriction on the patients' escorted leave within the community. When queried we were informed that they did not wish to be restrictive, but this is not consistent with Mental Health Act guidance.

Each ward conducted a monthly quality walk round, conducted by the quality lead, during which ward compliance with the Mental Health Act is assessed. The hospital linked with a local pharmacy who produced weekly audits of patient medicine cards to ensure they complied with the Act. Managers also conducted annual Mental Health Act audits.

The hospital did not have any informal patients within the hospital and did not accept informal patient referrals. Patients that were coming to the end of their detention under the Act or looking to become informal were supported towards discharge to a more appropriate setting.

Good practice in applying the MCA

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As of September 2019, 89% of the workforce in this service had received their mandatory training in the Mental Capacity Act. Staff spoken with demonstrated a good understanding of the Act and the five statutory principles.

At the time of the inspection, no patients were being cared for at the service under a Deprivation of Liberty Safeguard and the service had made no deprivations of liberty safeguards applications in the 12-months prior to inspection. The service had 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.

Staff stated that they gave patients all possible support to make specific decisions for themselves before determining that a patient did not have the capacity to do so. We were informed that occupational therapists and social workers were involved in capacity assessments. They reported that the most common capacity consideration was regarding patient's financial capacity and a decision specific best interests meetings would be held when a patient was deemed to lack capacity, taking into account the patient's wishes, feelings, culture and history. The hospital always referred patients who lack capacity to an independent mental health advocacy service and liaised with their solicitor if applicable.

The service reported that they monitored how well they followed the Mental Capacity Act, conducted audits of ward compliance with the Act and had introduced monthly Mental Capacity Act quality walk arounds. Compliance was discussed within clinical governance meetings. However, it was unclear how this related to ward staff, as they were unclear on how and where capacity information was documented. During inspection, ward staff were aware that capacity was assessed within patient ward rounds, but they were unable to tell us where to find documentation regarding patients' capacity. We were informed by senior managers that patients' capacity would be documented within their independent care review notes. However, capacity was not consistently recorded in the minutes of every meeting. Patients who had specific capacity concerns, such as around finances, did not have a clear record of best interests meetings or ongoing capacity assessments and the reference to patient capacity had limited information. For example, one simply said "lacks

capacity", another stated that they lacked capacity to manage their finances and had a listed power of attorney, but staff were not able to show us a record of the capacity assessment or best interests decision.

Are forensic inpatient or secure wards caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Throughout our visit we observed staff of all levels interact with patients in a kind and personable manner. Ward staff were engaged with patients in a pleasant and supportive way and spoke about patients in a respectful manner in the staff offices. We observed patient activities with members of the multidisciplinary teams, including occupational therapists, gym instructors and drama teacher and observed them to be attentive and supportive. Patients and senior managers, including the director of clinical services and the operational director of the North, knew each other by name and communicated in a familiar and kind manner.

We spoke with 17 patients on 03 January 2020 during ward specific focus groups, 28 patients during the inspection and received feedback from 12 patients using comment cards. Patients were largely positive about staff interactions and said that staff gave them help, emotional support and advice when they needed it and that they were able to approach staff. 28 patients referred to staff in only positive terms, reporting that staff were "caring", "respectful", "polite" and "listen to me". Patients stated that staff went "above and beyond", were "genuinely interested" in patient wellbeing, and one patient from Farndale described the ward manager as "my hero". We spoke with two carers during inspection who reiterated this and said the staff at Stockton Hall were "outstanding" and "went above and beyond" in their care of patients.

However, 13 patients reported negatively about staff approach. Two patients from both Boston and Dalby ward stated that staff could misconstrue what was "banter" and it sometimes felt like staff were "mickey-taking" or "had an attitude", one patient from Fenton stated that they felt that staff sometimes spoke to them like a child, and one patient

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on Farndale reported that a member of staff had sworn at them. Managers were aware of this and told us that it had been addressed in staff meetings and individual supervision. Managers reported that they felt some staff developed close relationships with patients and could forget their setting at times, staff had been reminded of the importance of boundaries and Dalby staff were provided with training in boundaries by the ward psychologist.

Most patients reported that staff approached them with dignity. Patients spoken with during inspection who had been involved in a restraint incident or spent time within seclusion reported that staff had carried it out in a respectful way. However, some patients did report that the care provided had impacted on their privacy and dignity. One patient reported to us that during their time in seclusion their bed pan was not removed before their food was brought in, other patients reported that being required to use bed pans in front of staff impacted on their wellbeing. Three patients stated that staff did not always knock before entering their bedroom or opening the privacy glass in their bedroom doors. Patients from Kirby ward reported that sharing dirty toilets impacted on their dignity.

Patients told us they were able to approach staff for support and that staff would plan additional support during difficult periods or significant anniversaries. We were informed by staff and patients that staff would often fulfil last-minute requests to facilitate escorted leave for important events for patients. For example, staff volunteered at short notice to work overtime in order to escort a patient to see their relative in hospital. Staff described their role and relationship with patients in very positive terms, with many describing it as “very rewarding”, albeit challenging at times.

Staff understood and respected the individual needs of each patient and directed and supported patients to access external services if they were unable to meet that need. Staff supported patients to develop their personal relationships, achieve their goals and to become integrated members of the community, internal and external to the hospital.

Staff followed policies to keep patient information confidential. When a complaint had been raised regarding confidentiality during handover on Dalby ward, staff acted promptly to resolve this. When incidents occurred in which patient confidentiality had not been upheld, for example

following an administrative error, staff apologised to patients and shared lessons learnt with staff. Staff and patients felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes on the wards to managers.

Involvement in care

Staff introduced patients to the ward and the services as part of their admission. Patients were provided with a welcome pack with information about the ward and service available to them. For patients on Fenton, staff visited the patient prior to admission to provide some familiarity during what was often a difficult period of transition for the patients.

All care records evidenced that staff involved patients and gave them access to their care planning and risk assessments. Patients could give feedback on their treatment preferences and staff supported them to do this. Staff supported patients to understand and manage their own care treatment or condition. They had clear aims for recovery and had personalised therapeutic and vocational activities.

Staff were not able to give any examples of instances where they had supported patients to make advanced decisions on their care. However, there was evidence within a patient's care record that staff had used an advanced decision made prior to entering the service to inform their care and had adhered to the patient's wishes.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties, using facilities such as easy read documents and regularly using the hospital's translation service.

Staff made sure patients could access advocacy services. They had general advocates who attended the wards weekly and access to independent mental health advocates as requested or required.

Staff involved patients in decisions about the service, inviting them to service user forums, reducing restrictive practice groups and service user forums. They also produced patient and carer experience surveys. Staff were able to evidence ways in which this had led to changes in

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service provision, such as the introduction of mobile phones to the wards. Patients were also involved in staff interviews and had recently taken part in occupational therapy and social worker interviews.

Staff supported, informed and involved families or carers. The hospital social workers took the lead in family and carer communication. They made contact with carers on patients' admission and kept them updated with information regarding patients' care. During the seclusion reviews we observed on Farndale ward, the social worker discussed family involvement with both patients. The hospital also linked with a local befriending service for patients who wished to access this support.

Staff helped families to give feedback on the service. Carers were encouraged to attend the hospital for visits and escorted patients on extended Section 17 leave. The hospital facilitated quarterly carers events, an Easter event, a summer barbecue and a Christmas meal with pantomime, which patients and carers were every complimentary of. Carers were encouraged to give written feedback after visiting the hospital and were sent carers surveys in the post.

Are forensic inpatient or secure wards responsive to people's needs?
(for example, to feedback?)

Good



Access and discharge

The service cared for patients from throughout the country. Patients were admitted from NHS and independent secure facilities as well as prisons. Six wards were able to provide tailored care for male patients with personality disorders, mental health illness, learning disabilities, autistic spectrum disorders as well as older adults. The hospital provided one female ward for patients with a personality disorder or mental health illness. Managers met weekly for a referrals meeting. Senior managers told us that prior to this meeting they declined any referrals for patients whose needs they could not meet, who did not present with an appropriate level of risk, or those who it was felt would not be beneficial for the current ward dynamics. Staff

endeavoured to visit patients prior to admission and introduce them to members of the team, particularly on Fenton ward where patients may have difficulty with the change in environment.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Patients who were discharged between 01 August 2018 and 31 July 2019 had had an average length of stay of 453 days on Boston, 563 on Kyme, 904 on Farndale, 1054 on Dalby, 1194 on Kirby, 1379 on Hambleton and 1761 on Fenton ward.

The hospital provided information regarding average bed occupancies for all wards in this service between 01 April 2019 and 30 September 2019, all wards reported average bed occupancies ranging above the minimum benchmark of 85% over this period. The lowest bed occupancy was on Farndale ward, which had 87% occupancy, all other wards had 93% occupancy or higher, Fenton ward had the highest level, with 99%. Farndale had had a period of time with a halt on admissions to allow the staff and patients a period of recovery following an increase in acuity on the ward.

When patients went on leave there was always a bed available when they returned and staff did not admit into leave beds. Patients were occasionally moved between wards, for example, a patient was moved from Kirby ward onto Hambleton ward. This was because their risk had decreased and it was felt they would benefit from a quieter and more settled ward environment. Other patients had been moved in response to safeguarding concerns or in response to further assessment of their clinical diagnosis. Patients were only moved when there were clear clinical reasons or it was in the best interest of the patient.

Staff sought to relocate patients to hospitals close to their home area or family members and incorporated this into discharge discussions. Staff did not move or discharge patients at night or very early in the morning. We were told that discharges were carefully planned and staff sought to facilitate a phased discharge, showing patients around the proposed hospital, introducing them to their new team and doing overnight trial leave where applicable. We were informed of one occasion when this had not been facilitated, and that was a result of a court judgement. All patients spoken with were aware of their plan for discharge, where they hoped to be moved to, and what they needed to achieve to enable this. However, patient care records did not have specific discharge plans and

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information regarding discharge was stored in different places. For example, one patient had an in-depth description of their discharge arrangements in a 1:1 record, other patients had a note within their independent care review notes and others had it listed within their social care plan, we were informed that this should be the case for all care records, but it was not consistent across the care records reviewed.

The service reported no delayed discharges between 01 January 2019 and 30 September 2019. Managers reported that some patients could find it difficult to find a new placement due to their historic risks. There could also be a delay in having referrals to high secure placements accepted due to waiting lists for admissions. The hospital worked with patients' care managers and coordinators to try to overcome these challenges.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom, which they could personalise. Patient bedrooms had posters, photographs and personal items displayed. Staff and patients from some wards reported that patients were unable to bring in their own bedding and blankets due to fire regulations, but other wards stated this was not the case. Two patients stated they wished to be able to re-decorate their bedrooms. Patients had a key to a lockable drawer in their bedrooms, that they could store personal possessions. There were further lockable cabinets in patient bedrooms that could be used to store personal items, but staff had the keys to access these. All wards, with the exception of Boston and Kirby, had en-suite facilities. Both Boston and Kirby were 24 bed wards, four bedrooms had en-suite shower rooms but the other 20 bedrooms shared 12 toilets, four shower rooms and one bathroom. At the time of inspection half of the toilets were locked on both wards.

All of the wards had designated quiet spaces or de-escalation spaces. The wards had activity rooms, such as crafts rooms and rooms with pool tables, Boston ward had a library. During inspection Dalby, Kyme and Farndale had locked pool rooms and Kyme also had a locked activity room. We were informed that this was to ensure the items were not weaponised and to ensure patient safety; however, the pool equipment was kept in the staff offices and craft equipment was kept in locked cupboards. The reducing restrictive practice log recorded that side doors to

activity rooms would be open, but this was not happening in practice. Allied health professionals reported that there was not enough room for 1:1 interventions and this could impact on patient privacy.

Both Boston and Kirby had one visitors' room. Patients informed us that they were required to pre-book the visitors' room and reported occasions when they have cancelled visits due to the room being double-booked. However, when discussed with carers, we were informed that staff on Kirby ward "bent-over backwards" to arrange alternative rooms for visits, even at short notice. All other wards had designated spaces to meet carers and have 1:1s. As part of the hospital's proposed refurbishments, the hospital planned to increase the number of rooms available for therapeutic interventions and create new family visiting rooms.

The wards had access to pay phones in ward communal areas and a ward mobile phone that patients could take to make phone calls in a privacy. The hospital had also offered all patients simple mobile phones with texting and calling functions. Patients had been requested to text and make phone calls in their bedrooms to maintain privacy. Patients were able to have smart phones, which were kept in the security lodge, to use during Section 17 leave, they were unable to bring them into the hospital for security reasons.

The service had a secure courtyard that patients could access to reach the security lodge and Galtres centre. Patients were required to be written up for Section 17 leave to access this area. Each ward had allocated periods in which they could access the courtyard. We were informed by staff and patients that unescorted patients were able to access the courtyard four times a day for 30-minute intervals and escorted patients were able to access the courtyard four times a day for 15-minute intervals. We were informed that this was due to restrictions on the number of people able to access the courtyard at any one time. The courtyard had floodlights and was covered by closed circuit television. Both the courtyard and ward gardens were locked at all times and patients required staff support to access them. Patients' access to the outside areas was restricted to daylight hours, at the time of inspection patients were not able to access them past 4pm, this increased at set increments as daylight hours increased. Staff from Boston, Kirby, Kyme and Fenton reported that

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there was a blanket approach to garden access, and all patients were escorted by staff when accessing this area as there were blind spots that could not be observed through other means, such as closed circuit television.

Patients could make their own hot drinks without being dependent on staff. Patients and staff on Farndale ward informed us that the patient dining room was locked from 11pm so they would have to ask staff for support if they wished to make a hot drink in the evening. Cold drinks containers were kept in the office on Fenton ward, this was at the request of patients, to ensure that they were not contaminated. Staff also kept toast and fruit within staff offices and patients would need to ask if they wished to have some. Patients were able to buy snacks from the shop / café and during Section 17 leave, which they could have access to at any time.

The service offered a variety of food options, patients received breakfast, lunch, an evening meal and supper and had access to snacks from the shop and toast and fruit on the wards. Patients were generally positive about the quality of food during the focus groups. However, during inspection four patients spoke positively about the food while nine spoke negatively, as did all comment cards that referenced food (seven). Those who spoke negatively made particular reference to it being bland and stated the portion size had reduced following the dietician's menu review and was no longer adequate. Staff were given the same food as patients during shifts and spoke more positively about the food on offer than patients did. Patients regularly raised food as a concern in community meetings and service user involvement meetings; both catering staff and the dietician had attended meetings in a bid to come to a resolution with patients. At the service user involvement meeting we attended during inspection, it was agreed that the dietician would attend the following meeting to discuss patients' concerns. The dietician informed us during inspection that they planned to conduct a nutritional analysis of the menus and portion sizes to ensure they were appropriate.

Each ward had access to takeaway services once a week, the time and day was different according to ward and had been agreed in community meetings. Patients were presented with a choice of two takeaways, the takeaway that gained the most votes was where patients would order from. We were informed that the quantity that patients were able to order was restricted to a main and a side to

ensure staff were able to carry the food from the security lodge. On special occasions, for example at New Year, patients informed us they were able to order from a fast food restaurant.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients to stay in contact with families and carers. Patients were able to apply for internal voluntary and paid positions, such as cleaning the gym, running the shop/café in the Galtres centre and caring for the hospital's animals. Patients were able to sell some things they had created within the shop, for example a patient on Farndale sold cushions she had made. Patients were also supported in voluntary and paid opportunities in the community, such as escorted leave to a decorating and maintenance role at a local sports centre, voluntary work at a local farm and cleaning a local church. One patient had recently been accepted to work with a local mental health advocacy service. The occupational therapy department had hosted a week-long event in November with the theme of vocational rehabilitation. They arranged for a volunteer coordinator and farm worker to attend and speak to patients and arranged focus groups to discuss the types of roles they would like to pursue.

Patients were supported to pursue educational progression. For example, a patient on Farndale had been supported in continuing their education in English and mathematics and had recently completed a level three exam. The service provided patients for whom English was not their first language with an opportunity to learn English and a patient on Kirby had been taking part in English language lessons, working to achieve a level two qualification. Patients had access to the recovery college and could also access the Open University where appropriate.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. The hospital facilitated patients accessing skype in order to see their family as they spoke to them. Patients said their families were encouraged to attend the hospital regularly and visits were facilitated, one patient on Kirby ward had daily visits facilitated with a family member. However, patients from some wards reported that they were unable to have unsupervised family visits or unsupervised skype conversations and a member of staff would always be present, this was the case for some patients who had been

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granted overnight leave with their families. A patient on Kirby ward was able to have a reduced staff presence, a member of staff remained outside of the room during a visit they had at the time of inspection.

Carers spoken with said that staff supported them to maintain contact and held quarterly carers events to encourage families to celebrate together. At Christmas the hospital had held a pantomime and Christmas meal for patients and carers. The Galtres centre had a visitors' book with lots of compliments in following the event. The service also linked in with a local befriending service for patients to access if they wished to.

Meeting the needs of all people who use the service

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information was displayed on display boards on each ward. Information boards also informed patients of employment and voluntary positions internal and external to the hospital as well as upcoming events, such as the upcoming Burns night brunch, which gave patients the option to have haggis, potato scones and lorne sausage with their brunch. There were also photographs displayed in communal areas of some wards, such as following a trip to the seaside on Hambleton. One of the display boards on Farndale ward had been removed by a patient, but patients were able to access information from the staff offices. All wards also produced welcome packs for patients, which oriented them to the ward, activities and therapies available, rules of the ward and mutual expectations.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Hambleton ward cared for some older adult males, some of whom had mobility concerns. The main ward was situated on the first floor and the bedrooms were on the ground floor. The ward had a stair lift and an elevator for staff and patients to use in place of the stairs. All other wards were on the ground floor and had disabled access. Staff on Hambleton had not completed dementia specific training, but training was available to them. A patient had recently been diagnosed with dementia and staff were seeking discharge to a more appropriate care setting for the patient.

We saw evidence within patient care plans that they had been supported to have their communication needs met. For example, one patient had been provided with a visual

timetable as they were unable to read or write; patients on Fenton ward had their care plans produced in an easy read format, had access to tablets and information in a pictorial format. However, staff reported that the easy read facility was not so readily available for patients on Kyme ward and they felt they would benefit from improved shared learning in this area. A patient on Hambleton ward also had access to a communication aid to assist them in communicating with staff.

The hospital was responsive to patients with protected characteristics as defined by the Equality Act and supported patients from LGBT and black and minority ethnic communities on the wards. Staff worked with patients on an individual basis and we saw care plans that reflected the patients' sexual orientation, sexuality and their gender identity. Staff were able to give examples of supporting transgender patients, referring to them by their preferred name and pronoun and supporting them to buy new clothing. Staff also respected patient's rights to decide who knew of their sexuality and maintained their confidentiality. The patients had created an LGBT group within the hospital, staff and patients who identified as LGBT and those who did not, were invited to attend meetings to engage in discussions and raise awareness. Staff on Kyme also informed us of a bullying group designed to assist patients to speak up if they had been subject to discrimination.

The service had information leaflets available in languages spoken by the patients. There was evidence within two patients' care records on Kirby ward that they had at least weekly access to an interpreter, who assisted patients when their rights were being read, during multidisciplinary reviews and psychology sessions. Patients' care records also reflected their preferred music and television channels to ensure they were able to have entertainment in their first language.

Patients had access to spiritual, religious and cultural support. The service had a chaplain and imam who visited the wards weekly. Patients had access to a multi faith room with different religious texts and there was evidence within observation records and care records of patients utilising this. Patients were also able to access a local church. The service provided a variety of food to meet the dietary and cultural needs of individual patients and offered staff and patients halal, vegetarian and vegan options for every

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meal. Fenton ward was also provided with a different menu to the other wards to account for patients that were at risk of choking or patients' sensory needs as part of their autistic spectrum disorder.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and patients and carers spoken with on inspection were familiar with the process.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients spoken with reported that they felt comfortable and confident to raise complaints to staff, the ward manager and the complaints officer. Those who had made complaints reported that they had received a swift response to their complaint and had been happy with the outcome, two patients had investigations still pending and were aware that their concern was being looked into. One patient on Kyme disagreed with this and reported that they had not felt listened to and "felt like a number".

Staff knew how to acknowledge complaints and the hospital had a dedicated complaints officer. Staff understood the policy and 97% of staff had completed the service's mandatory training in handling complaints. They reported that patients were supported and encouraged to raise concerns. The service attempted to manage complaints on a ward level, with a response given immediately where applicable. Complaints were reviewed within monthly clinical governance meetings and staff meetings. Managers analysed the information to identify themes, they shared feedback from complaints with staff and learning was used to improve the service.

The service received 143 complaints between 01 August 2018 and 30 September 2019. 22 of these were upheld, 22 were partially upheld and the remaining 99 were not upheld. No complaints were referred to the Ombudsman. The ward that produced the highest number of complaints was Dalby ward, which had documented 68 complaints in the period; the second highest number was recorded on Farndale ward, which had recorded 19; Fenton produced the lowest number, with four complaints over the period. The hospital had identified the trends in complaints received during this period; the most common was round

nursing care, the second was bullying or harassment from another patient and the third was approach of staff. One of the lessons learnt from patient complaints was that the window to the office was closed on Dalby ward as patients were able to hear staff during handover when it was ajar.

The service used compliments to learn, celebrate success and improve the quality of care. The service did not provide us with quantity of compliments received in the year prior to inspection but did inform us of trends. They informed us that they received a large number of compliments following family and carer quarterly events: the summer BBQ, carers Christmas party and the Easter tea which was hosted by patients and staff. They also reported that compliments themes centralised around the clinical care and treatment that patients have received and communication between the hospital, patients and carers.

We reviewed some compliments in the visitors' book, located within the Galtres centre. Family and relatives had noted the significance of the carer Christmas party, writing: "thank you very much for this lovely meal and event. It is the first time I have had a meal with [my family member] for seven years. Much appreciated!!" and "once again the team have hosted a fabulous family afternoon. Great food, inclusive entertainment and warm atmosphere created by the friendly staff, friends and family. Thank you so much".

Are forensic inpatient or secure wards well-led?

Requires improvement 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Ward managers were all experienced mental health nurses and each manager had the support of a clinical lead. Leaders had a good understanding of the services they managed. Managers could explain clearly how the teams were working to provide effective and responsive care for patients. They were aware that there were areas that required improvements, such as the environment and accurate documentation, and had produced strategies to address these, such as additional training for staff.

Most staff reflected positively about the ward managers and clinical leads on their wards. Staff on Kirby and

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Farndale were particularly positive about the hands-on support provided by their ward managers. Boston ward had had multiple managers in a short period; at the time of inspection there was no ward manager in post and the ward was being supported by the nurse development lead and director of clinical services. While Boston staff were positive about the approach of their current management, they told us that the frequent changes in leadership had impacted on staff morale and sense of value. Some staff and patients also raised concerns regarding the leadership on Dalby ward; reporting that they did not listen to staff when they had voiced concerns regarding patient risk and they did not feel valued by managers. Staff also stated that there had been incidents when the ward manager and clinical lead had spoken to staff in an aggressive manner or “snapped” at staff. The inspection took place one month following a serious assault on staff members on Dalby ward. The focus groups took place the week after the incident. At that stage, both staff and patients were very distressed by what had taken place and reported that they felt that management before and after the incident had not been adequate. At the time of inspection, staff and patients felt safer and more supported but continued to voice concerns. Other staff disagreed with this and stated staff sent them thank you emails and provided good support during a difficult period.

Senior managers were visible within the hospital. Directors spent time on the wards and all staff and patients knew them by name. Staff and patients spoke in universally positive terms about the leadership provided by the director of clinical services and the operational director of the North.

The service operated a bronze, silver and gold on-call system, representative of the different levels of management, for staff to utilise to gain managerial advice outside of working hours. Staff were given guidelines on which level to approach for different concerns; for example, for a patient absconson, staff would approach the silver on-call manager.

Vision and strategy

The service shared the Priory’s organisational values. These were:

- “Putting people first - we put the needs of our service users above all else,

- Being supportive - we support our colleagues, our service users and their families when they need us most,
- Acting with integrity - we are honest, transparent and decent. We treat each other with respect,
- Being positive - we see the best in our service users and each other and we strive to get things done. We never give up and we learn from our mistakes, and
- Striving for excellence - for over 140 years, we have been trusted by our service users with their care. We take this trust seriously and constantly strive to improve the services we provide.”

Their vision was: “to be outstanding in the field of healthcare, to continue to develop our approach to quality improvement and quality assurance. The hospital is committed to delivering safe, compassionate, effective care that strives for good clinical outcomes with the focus on the provision of quality care and treatment in an environment that is safe for both patients and staff. We value compassion; this will be the embodiment of our care delivery. We will respect the diversity of our patients and staff. We will involve our patients and their families and carers to take an active role by supporting the patients and adopting the principles of recovery.”

Staff knew and understood the provider’s vision and values and how they were applied in the work of their team. The provider’s senior leadership team had successfully communicated the provider’s vision and values to the frontline staff in this service, the provider’s values were on posters throughout the hospital and on computer home screens.

Staff had reported within the employee engagement forum that they felt they wished to have more involvement and communication regarding service development, as ward staff felt information did not always reach them. In response the senior managers within the hospital held two open staff meetings to discuss developments within the hospital and the Priory, to invite questions and suggestions from the staff team.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The hospital held local and regional “your say forums” for staff to feedback on the service to senior managers. They sought advice of the staff that changes impacted and granted staff autonomy over some

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aspects of ward development. For example, gym instructors had been able to design the new sports hall floor alongside patients and Fenton ward's progression as an accredited service had been led by staff on the ward.

Managers could explain how they were working to deliver high quality care within the budgets available and were able to give examples of where they had prioritised service development and patient safety over budgets. The hospital was prepared to invest heavily in the future of the hospital and had commissioned extensive building plans to improve the quality of the hospital environment. However, some staff felt that the hospital should increase the budget assigned to staffing, staff retention, and maintenance of the ward environments.

Culture

Most staff reported that they felt positive and proud about working for the hospital and their individual teams. They felt valued and respected by their peers, managers and the service. However, staff spoke less positively about working for Priory as a provider, reporting that they did not feel valued by them. Most staff reported that they had good working relationships across wards and disciplines. Four staff reported that different roles held different value, some health care support workers felt that they were less valued than nurses and some nurses felt less valued than other multidisciplinary staff.

All staff spoken with reported that they knew how to use the whistle-blowing process and stated would feel comfortable and confident to raise a concern without fear of retribution. Some staff were not aware that the hospital had freedom to speak up guardians but did know that there was a whistleblowing hotline. Managers dealt with poor staff performance when needed. Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff were supported to undertake additional training and commitments to encourage their career development. For example, a nurse on Dalby ward was a trained dialectical behavioural therapist. The hospital had supported nurses to undertake non-medical prescriber training; an occupational therapist had requested to be a mentor and had been supported to take on a student; another occupational therapist had been supported to undertake

model of human occupation training and sensory integration training. Health care support workers had been supported to become nursing associates and to do their nurse training.

The hospital informed us that the Priory group monitored the ethnicity, gender, age and reported disabilities of the existing workforce and of applicants for jobs, including promotion, and would take appropriate action to address any problems that may be identified as a result of the monitoring process. Managers were aware of some challenges that staff with protected characteristics may face within the hospital. Staff informed us that they were offered support if they had come against any discrimination. Staff reported that when they were spoken to in an abusive way, it was usually said by patients in a state of anger and they often received apologies following this. They stated that they could approach managers for support and senior managers informed us they were mindful that this could be an area of concern and would approach staff to offer support following incidents.

The hospital had an average sickness rate of 3.2% and staff had access to support for their own physical and emotional health needs through an occupational health service. There was evidence of ward staff moving to administrative roles in response to their physical or psychological health needs. The provider had linked with an independent support service that staff could access for both personal and professional reasons. This service provided support over the phone and face to face and had facilitated group support following a serious incident on Dalby ward.

The service made reasonable adjustments for staff members' personal and professional needs. For example, they adjusted shift patterns to account for staff attending university courses, or childcare needs; they also provided a staff member with visual aids to assist them in their role.

The service participated in the Priory staff awards and were able to nominate colleagues for recognition. The organisation had recognised the achievements of Fenton ward by awarding them the team of the year award following their accreditation.

Governance

Staff undertook or participated in local clinical audits and quality walk arounds, led by the hospital's quality manager. However, our findings during inspection found a lack of oversight. Governance structures were not consistently

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implemented or effective; areas of concern had either not been identified by the process or effective in rectifying the concerns. There were errors and omissions in multiple forms of patient records and documentation reviewed, some meetings were cancelled and meeting decisions were not always documented.

The systems and procedures to ensure that wards were safe, clean and well maintained were not effective across all wards; some patient areas were unclean or tired, blind spots had not been mitigated against, not all staff were familiar with the ligature risk assessments and some information on the assessment was unclear. There were errors in three patients' Section 17 leave paperwork; Mental Capacity Act assessments and best interests decisions were not clearly documented and ward staff did not know where to find this information. There was inconsistent recording of patients' discharge planning and in the quality of daily intervention records, staff did not routinely document when they had 1:1 interventions with patients. Seclusion paperwork did not consistently record when patients had eaten, showered, or when bed pans had been removed within 15-minute observations. There was a lack of clarity in two post rapid tranquilisation monitoring forms from Farndale ward. There were errors in clinical processes as 12 of the 66 medicines cards reviewed were missing at least one signature, some open medicine on Kirby did not have a date of opening and fridge temperatures on Boston had been out of range on 22 occasions over two months without action. Staff did not appropriately address some of the blanket restrictions listed in the reducing restrictive practice log or carry out the agreed actions. Ward rotas were inconsistent in number of staff allocated and staff routinely moved between wards without record of staff movement or final staffing numbers on each ward.

The hospital was aware that accurate documentation was an area of concern and reported that they were beginning workshops to train staff in appropriate recording within documents such as seclusion records.

Staff informed us during the focus groups that some meetings were regularly cancelled. They gave us examples of the health and safety meeting, your say meeting and reducing restrictive practice meetings, which we were informed were regularly cancelled last minute, with a staff or room availability cited as the reason. Documentation showed that the reducing restrictive practice meeting group had been held in June, September and October

2019, staff reported that these should have been conducted monthly. However, the provider informed us that there were no fixed timeframes between meetings; meaning that the provider facilitated seven meetings at irregular intervals through the year. The health and safety meetings were scheduled to take place on a quarterly basis, and while four took place within the 12-month period, meeting deferrals meant that these also took place at irregular intervals, the longest being between 12 September 2019 and 03 February 2020. The your say meetings had taken place on seven out of nine months between January 2019 and September 2019, however another meeting did not then take place until January 2020. We were informed by the provider that this was because it had been decided that they were not required at such regular intervals; however, this decision was not documented within the minutes and a meeting had been scheduled for October during the meeting in September.

Safeguarding and service user involvement meetings were listed as priority meetings which went ahead at regular intervals. The clinical governance and operational North meeting also consistently ran monthly.

Staff were trained and supervised; patients were assessed and treated well; and staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

There was a clear framework of what must be discussed at a ward, team or hospital level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level.

Management of risk, issues and performance

The hospital had a hospital risk register that took account of issues such as monitoring of the nurse call system after an alarm did not sound due to a weak signal, staffing levels and the risk of a breach in security. Risks on the register were red amber green rated according to the potential impact and the probability of the incident happening. The hospital director was listed as responsible for the risk and the risk register was discussed as a standing agenda item in clinical governance meetings. Staff maintained and had access to the risk register at management level. Staff at ward level could escalate concerns when required through management.

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They responded promptly to issues of security and put measures in place to try to prevent the incident happening again. For example, a power surge had caused the magnet on the air lock to disengage, the back-up battery had also ran out of power, causing a security risk. In response, the maintenance team replaced the battery and put a light on it to display when it needed charging.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. However, staff reported that the equipment and information technology needed to do their work was not always effective. Ward staff stated that there had been difficulties with the computer system which had caused delays with paperwork and incident reporting. This had been discussed within clinical governance meetings. Staff reported that there were not enough computers and that those remaining often failed, impacting on the amount of time staff could spend out of the office. Staff on Kyme ward booked slots to use the ward computers. Staff reported that they had previously had laptops that they could take onto the ward and this had made it easier to create collaborative care records, however these were no longer in use. The patient computers had also been out of service since November 2019; the hospital informed us that they were not able to resolve it at a hospital level and had escalated this to the provider on multiple occasions, but it had not been resolved.

Staff stored patient information securely and all staff had individual login credentials for computers. Staff reported incidents using an electronic record system and made notifications to external bodies as needed. Wards received administrative support from a ward clerk, the hospital also had Mental Health Act administrators and general administrative staff who worked throughout the hospital, including in the security lodge.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement, such as when administrative errors had been made, or when staff were required to undertake mandatory training.

Engagement

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients were able to give feedback in weekly community meetings on the wards, monthly service user involvement and reducing restrictive practice meetings, which were attended by senior managers within the hospital. Meetings were open to all patients, but wards each nominated a ward representative to attend to pass on the opinions of their ward. Patients were able to attend regional involvement groups; at the time of inspection there was a regional forensic capture group taking place. The head occupational therapist, who was the service user involvement lead, provided feedback from the patient groups and patients were also able to attend the meeting in the afternoon. Carers were sent carer experience surveys in the post and were asked for feedback following visits and carers events. Managers gave examples of ways in which feedback from these formats had led to service development, such as the introduction of patient use of mobile phones on the wards.

Patients and carers were involved in decision-making about changes to the service. Patients had been involved in recent social worker and occupational therapist interviews for the hospital. They were provided with support and training from the occupational therapy department prior to undertaking this.

Staff reported that they found the management team to be responsive. Allied health professionals in particular reported that they felt able to approach senior managers regarding improvements they felt could be made to their department or role and felt that these would be considered in earnest.

Directorate leaders engaged with external stakeholders such as care coordinators, commissioners and NHS England. Commissioners spoken with stated that the service maintained contact and they had seen areas of improvement following feedback.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, the head of psychology had been supported to travel to San Francisco to participate in radically open dialectical behavioural therapy training.

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They returned to the hospital and trained others in facilitating the therapy and patients who had participated in the 13-week course spoke positively about the impact this had had.

Staff had opportunities to participate in research, particularly within the psychology department. They ran ongoing research programmes in topics such as staff approach to patients with sexualised behaviours, and another in staff involvement in HCR20s, and reported their findings to staff.

Different wards within the hospital had ongoing improvement initiatives. For example, Dalby ward had implemented stop and think groups onto the ward, which was supported by staff who had had training in group work and motivational speaking. The manager credited these groups with assisting six patients to be discharged to a low secure setting within the previous 12-months. Senior managers also informed us they were introducing a training programme for staff, which would enable patients to give staff a better understanding of their experience as an inpatient in a secure setting.

The hospital was engaged with different forums within the Priory and senior managers and consultants regularly met with managers from other hospitals to share learning and discuss improvements and trends. For example, the ward manager for Kyme was a reviewer within learning disability

mortality reviews; and the ward consultant was involved in the Priory's learning disability forum and had taken discussions, such as introducing dysphagia and swallowing audits to clinical governance meetings.

They participated in national audits relevant to the service, such as the national audit of schizophrenia, NHS Commissioning for Quality and Innovation for managing a healthy weight in adult medium secure care, and took part in the Quality Network for Forensic Mental Health Services annual quality peer review. The service used these as an opportunity to inform quality improvement within the service and to review their performance in comparison to similar services.

Fenton ward had been awarded an advanced award by the Autism Accreditation Award Committee, part of the National Autistic Society. They were the first medical facility to achieve the award. (Hospitals are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date or review date whereby the service will need to be re-assessed in order to continue to be accredited.)

Outstanding practice and areas for improvement

Outstanding practice

Fenton ward had been awarded an advanced award by the Autism Accreditation Award Committee, part of the National Autistic Society in response to the specialised care provided on the ward and the environmental adaptation made to support the patients. They were the first medical facility to achieve the award.

The service was dedicated to enabling staff to pursue further learning and development. For example, training

staff in wound care and stoma care and supporting the head of psychology to travel to San Francisco to participate in radically open dialectical behavioural therapy training.

The service was open about patients' sexual needs being an important aspect of their care and was sensitively incorporated this into care planning. The psychology department had also conducted a research project looking into staff responses to patients' sexualised behaviours, which was used as a learning opportunity for staff.

Areas for improvement

Action the provider **MUST** take to improve

- The hospital must ensure that blanket restrictions are assessed, discussed with patients, regularly reviewed and that agreed actions are implemented effectively.
- The provider must ensure that all ward areas and patient toilets and bathrooms are clean; and ensure that maintenance is undertaken in a timely manner.
- The provider must ensure that patients' dignity is maintained in seclusion and patients' continence needs are managed effectively.
- The provider must ensure the ward environments are safe and that all staff know how to mitigate any risks posed to patients and staff by the environment.
- The provider must ensure it has effective governance structures and processes to provide oversight and assurance of all aspects of service delivery, to be able to identify and improve practice in a timely manner.

Action the provider **SHOULD** take to improve

- The provider should ensure that more consistent ward rotas are created to ensure an appropriate skill mix and continuity is maintained for patients.
- The provider should ensure that staff keep clinic rooms clean and tidy and ensure clinical equipment is properly maintained.
- The provider should continue to engage staff in boundaries training and ensure that all staff communicate with patients in a kind and respectful manner.
- The provider should review the quality and quantity of food provided to patients to ensure it meets their needs.

This section is primarily information for the provider

Requirement notices

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

There were blanket restrictions in place on all wards that were not necessary to prevent, or not a proportionate response to, a risk of harm posed to or by the patients.

The service did not evidence that they had appropriately supported patients to attend to their continence needs while in seclusion.

This was a breach of regulation 13 (4) (b) (c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Not all premises and equipment were clean, suitable for the purpose for which they are being used or properly maintained.

This was a breach of regulation 15 (1) (a) (c) (e)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The governance systems in place did not provide appropriate oversight. The service did not assess,

This section is primarily information for the provider

Requirement notices

monitor and improve the quality and safety of the services provided to patients effectively through their auditing processes as there were multiple administrative errors in documentation.

This was a breach of regulation 17 (2) (a)