Elysium Healthcare Limited

The Spinney

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Our rating of this location went down. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean, and there was an extensive refurbishment programme under way. The wards had enough nurses and doctors. Staff assessed and managed risk well. They managed medicines safely and followed good practice with respect to safeguarding. There was a clear emphasis on honesty and learning when things went wrong.
- The environment was peaceful and calm. There were extensive grounds that were well maintained, with areas that patients had been involved in building, such as the hope garden.
- The provider worked with patients to understand their perspective of security and their feelings about it. Patients and carers were actively involved in the provider's restrictive interventions reduction programme.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They had a clear view of how physical wellbeing and a healthy lifestyle was essential to recovery. They involved patients in developing their care plans and encouraged them to take responsibility as much as they could. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- There were strong relationships with other organisations, so that patients had options and choices away from the hospital, including education and work experience. Patients had a wide-ranging choice of activities on site. The hospital had outstanding provision that included a gym and sports hall, plus music, art and photographic studios.
- Staff engaged in clinical audit to evaluate the quality of care they provided.
- The service understood how physical wellbeing and healthy living supported mental and physical health and was integral to recovery. There was a comprehensive healthy living programme that educated patients about fitness, healthy eating and nutrition. In addition, two physical healthcare nurses supported patients with their physical health needs.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that staff received training, supervision and appraisal, and encouraged them to develop their skills and share best practice. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- There was a clear culture of empowering patients by ensuring they were central in their care. Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They recognised the needs of diverse groups. They actively involved patients and families and carers in care decisions. There was strong support for carers, so they could engage with plans for the service and share their views and experiences.
- Staff acquired the skills they needed to develop an enhanced programme of specialist care to meet the specific needs of a patient whose presentation was outside their usual expertise.
- We saw dedicated and motivated teams who worked hard for patients, carers and staff, to enhance their experience and optimise recovery.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. Staff supported patients to use local services, demonstrating the recovery ethos and emphasis on living in the community. There was good participation with other services and the community that was central to care planning and recovery. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

- The service was well-led, and the governance processes mainly ensured that ward procedures ran smoothly. There was an ethos of joint decision-making. Patients were actively involved in developing the service. This meant that patients were involved in all aspects of service planning and delivery, via a range of meetings from ward community meetings, the patients' council and governance.

However:

• Some governance processes were not effective. For example, managers did not ensure fire evacuation procedures were carried out according to policy. Some restrictive practices, such as opening mail in front of staff and the practice of selecting patients to be searched in the rehabilitation service, were not individually risk assessed. Some governance documents were not dated.

• There were no risk assessments on Hindsford ward for patient steps without handrails, and no means for patients to call for assistance in one of the communal bathrooms on Lever ward.

• Some medicines on Hulton ward were out of date, and fridge temperatures were not always taken and logged as required.

• On Hulton ward, required checks were not always completed and documented in line with national guidance following the use of rapid tranquilisation.

• Pharmacy visits did not take place consistently and in accordance with contractual arrangements.

• Furnishings on some of the wards were damaged and in poor condition. The communal shower on Hulton ward was in a poor state of repair and did not ensure patients' privacy and dignity.

• Some patients' advanced statements were not reflective of their current wishes and preferences.

• Patients did not always have access to snacks between meals. Some patients were not happy with the food choices and portion sizes available at mealtimes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good 	We did not rate this core service at the last inspection. At this inspection we rated it as good because it was safe, effective, caring, responsive and well led. The rehabilitation mental health wards for working age adults were a small proportion of hospital activity. The service provided high dependency rehabilitation and recovery for men aged 18 years and over who had complex mental health issues. It focused on reducing challenging behaviours and supporting patients to engage with their families and communities. The main service was forensic in-patient or secure wards. Where arrangements were the same, we have reported findings in the forensic in-patient or secure wards section.
Acute wards for adults of working age and psychiatric intensive care units	Good 	The psychiatric intensive care unit was a small proportion of hospital activity. The main service was the forensic inpatient or secure wards. Where arrangements were the same, we have reported findings in the forensic inpatient or secure wards section. We did not rate this core service at the last inspection. At this inspection we rated safe as requires improvement.
Forensic inpatient or secure wards	Good 	Our rating of this service went down. At this inspection we rated it as good because it was effective, caring, responsive and well led but safe required improvement.

Summary of findings

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Summary of this inspection

Background to The Spinney

The Spinney is an independent hospital that is run by Elysium Healthcare Limited. It is registered to provide the following regulated activities:

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

The service provides medium secure, low secure, psychiatric intensive care and rehabilitation services for male patients. It has 97 beds split over nine wards and units.

The forensic inpatient secure wards were:

- Hesketh ward, a 15-bed medium secure ward
- Hindsford ward, a 10-bed low secure ward
- Lever ward, a 15-bed low secure ward for people with a learning disability and/or autism
- Shevington ward, a 14-bed medium secure ward
- Pennington ward, a 10-bed medium secure ward
- Rivington ward, a 16-bed medium secure ward.

The psychiatric intensive care unit was:

- Hulton ward, a 10-bed psychiatric intensive care unit. At the time of the inspection only seven beds were open.

The rehabilitation unit was:

- The Coppice, a seven bedded ward
- Milford, currently a self-contained flat for one patient.

The service had a registered manager. This is the third time we have inspected The Spinney since it has been managed and overseen by Elysium Healthcare Limited.

We last inspected the Spinney in 2018. The service was rated outstanding following that inspection. There were no regulatory breaches and no actions to be taken that would have led to a regulatory breach if not carried out at that inspection.

The main services provided by this hospital are forensic inpatient or secure wards. Where our findings on the forensic inpatient or secure wards – for example, management arrangements – also apply to other services, we do not repeat the information in the reports for those services but cross-refer to the forensic inpatient or secure wards part of the service.

What people who use the service say

In relation to forensic secure wards:

Summary of this inspection

We spoke with 11 patients across the medium and low secure forensic wards. They told us that, overall, they received good care and felt safe. They said staff were respectful and treated them with kindness and compassion. Patients felt listened to and involved in their treatment. They could have a copy of their care plan if they wanted it. However, nine of the 11 patients we spoke with said there was not enough variety of food at mealtimes, and the portions were too small. Some patients said they felt hungry between meals. One patient told us they were not allowed a bowl of cereal in place of their lunch, and another patient said snacks were not available at night. Two patients told us they would have liked to have gone out for fresh air when they wanted to because they could only access outside space at set times.

In relation to psychiatric intensive care services:

We spoke to three people on the psychiatric intensive care unit who all said the staff were visible on the ward and were very caring, helpful and respectful. However, all three patients said the small communal shower room was a concern. They told us that it leaked onto the communal corridor floor, and it didn't always preserve dignity. One patient told us there needed to be more choice on the food menu and larger portions. Two patients told us their leave had been cancelled because there were not enough staff to facilitate it. They did not like being limited to the number of times they could access electronic cigarette breaks and fresh air, and that the hot water was not hot enough and access to hot drinks was set from 6: 00 a.m. to 11:00 p.m. One patient said the limited access to ground leave was not enough and another patient said there was not enough to do.

In relation to mental health rehabilitation services:

We spoke with four people using the rehabilitation service. All those we spoke with told us they felt safe on the ward. They each had their own bedrooms, which they could lock. They said the atmosphere was quiet and calm. They thought there were enough staff and that they were kind and supportive. They thought the food provided was good and said it was healthy.

All patients understood that they could have copies of their care plans, but some patients did not want them. They told us how they were involved in their care and about their plans for moving on. Three patients described how they managed their own medicines and the support staff provided. Three of the people we spoke with shopped and cooked for themselves. One patient told us about his employment outside the hospital.

The people we spoke with described the activities they took part in, both at the hospital and in the community, such as education, swimming, the gym, art, music and photography. One had won a Koestler award after staff submitted their work. The Koestler Awards is an annual scheme to award creative work in literature, the arts or sciences by people who are physically confined, such as in secure hospitals or prison.

How we carried out this inspection

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed. This inspection was to seek assurance about this decision and to identify learning about the DMA process. We usually focus on two key questions during these visits. Was the service safe? And was the service well-led?

However, the evidence we found during this inspection covered all five of our key questions, so our report includes them all and we have therefore reassessed our ratings and provided a new rating for the service.

Summary of this inspection

• 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.

The inspection team comprised of three CQC inspectors, two specialist advisors and two experts by experience.

During the inspection visit, the inspection team:

- spoke with the registered manager
- spoke with the lead consultant psychiatrist
- spoke with the lead nurse and the clinical nurse manager
- spoke with the patient recovery lead
- spoke with representatives of the patients' council
- spoke with the Mental Health Act administration team
- spoke with the director of policy and regulation who advised us on the role of the freedom to speak up guardian
- reviewed staff training, supervision, and appraisal records
- reviewed investigations into complaints
- reviewed investigations into incidents
- spoke with the independent mental health advocate
- collected feedback from the local authority and commissioners
- observed a meeting of the reducing restrictive interventions group
- looked at a range of policies, procedures and other documents relating to the running of the service
- collected feedback from commissioners
- looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with the ward managers
- spoke with 17 other staff, including doctors, nurses and health care support staff
- spoke with 19 people who were using the service
- spoke with five carers
- reviewed 19 care and treatment records of people using the service
- attended a multidisciplinary meeting and a manager's communication meeting
- carried out checks of medicines management.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The provider and staff recognised how physical wellbeing and healthy living supported mental and physical health and was integral to recovery. In addition to the regular weekly gym, swimming and multiple sports sessions, there was a comprehensive healthy living programme, led by a physical health and wellbeing coach, that educated patients about fitness, healthy eating and nutrition. The hospital had outstanding health facilities including a sports hall, a well-equipped gym and a swimming pool. In the grounds, there was a sports track and a fishing lake. There was a physical healthcare suite, therapy kitchen and a shop where patients could purchase healthy snacks, drinks and electronic cigarettes. There were strong relationships with external organisations, so that patients had many options and choices away from the hospital, including education and work experience. There was also a wide choice of activities on site. The hospital had outstanding facilities that included access to music, art and photographic studios where patients could develop skills alongside nurturing their mental wellbeing.
- Care and treatment focused on supporting recovery and developing independent living skills, in preparation for leaving hospital. The provider offered a range of training, and there were 'real work' and vocational experiences such as painting, woodwork, gardening, creative landscaping, cleaning and shop assistant, which provided patients with opportunities to develop skills. Training was seen as an opportunity to understand patients' outlook and develop their daily living skills, independence and confidence, supported by real work experiences. The provider had also developed strong links in the community that were beneficial for employment and college courses, so that patients had meaningful experiences of working and learning outside the hospital. Staff encouraged them to participate in community opportunities and to build their life in the community, using facilities such as the gym and primary healthcare, to develop their skills in preparation for discharge.
- The provider worked proactively with patients to understand their perspective of security and their feelings about it. Patients and carers were actively involved in the provider's restrictive interventions reduction programme.
- The provider understood the significance of carers in optimising recovery, and provided robust support for carers, so they could share their thoughts and experiences. There was a carers' forum that met regularly during the year, and which provided mutual support, understanding, learning and feedback for improvements in the service. During the pandemic, this was facilitated using technology, and there were plans to recommence the face-to-face forum. The provider had supported the carers to develop a carers' charter that explained their rights and the support they could expect from the provider. Regular newsletters were circulated to keep carers up to date with life at the hospital. Carers were regularly represented at various meetings, and they were involved in governance, working collaboratively with the provider to drive improvement. The provider offered support to enable carers to attend, such as financial support for travel costs, or transport.
- The environment all around the hospital was exceptionally peaceful and calm. There were extensive grounds that were well maintained, with areas that patients had been involved in planning and building, such as the hope garden.
- Patients were involved in all aspects of service planning and delivery, via a range of meetings from ward community meetings, the patients' council and governance. They were also involved in wider governance, with representation at the corporate provider's advisory group and feeding back to the hospital's clinical governance meetings.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

• The provider must ensure that all restrictions, such as opening mail in front of staff, and the practice of selecting patients to be searched in the rehabilitation service, are individually risk assessed and compliant with the Mental Health Act Code of Practice (Regulation 13 (1) (2) (4) (b).

Summary of this inspection

Action the service SHOULD take to improve:

• The provider should continue to ensure that staff practice fire evacuation procedures in line with the fire risk assessment and patients' personal evacuation plans.

• The provider should ensure there are risk assessments for areas of the hospital that have steps without a handrail.

• The provider should ensure there are means for patients to call for assistance in the communal bathroom on Lever ward.

• The provider should ensure that it only stocks medicines that are in date and that fridge temperatures are taken and logged as required.

• The provider should ensure that all required checks are completed and documented in line with national guidance following the use of rapid tranquilisation. • The provider should ensure that pharmacy visits take place consistently and in accordance with contractual arrangements.

• The provider should ensure that all patients have access to snacks outside mealtimes.

• The provider should ensure that patients are able to make advance statements that are reflective of their current wishes and that their decisions are reviewed.

• The provider should ensure that the communal shower on Hulton ward is in a good state of repair and effectively respects patients' privacy and dignity.

• The provider should ensure that all governance documents have been dated correctly and updated when required.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

We did not rate this core service at the last inspection.

At this inspection we rated safe as good.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We reviewed the ward ligature audit and noted that all ligature points noted had ongoing mitigating actions. However, the document was not dated so it was not possible to see how recently it had been completed or whether it was current. We raised this with the ward manager who assured us that they would take appropriate action.

Staff could observe patients in most parts of the ward. Where they could not, such as upstairs bedrooms and corridors, they mitigated risks through care planning and individual risk assessment, and observation.

There was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. All the rooms had patient call alarms.

Maintenance, cleanliness and infection control

Long stay or rehabilitation mental health wards for working age adults

Good

Ward areas were clean, well maintained, well-furnished and fit for purpose. We toured the ward and the separate accommodation that one patient was using. The premises were all clean. Patients did some of the cleaning themselves, alongside the staff and a housekeeper. There was a cleaning roster on the wall. Cleaning equipment was colour coded for use in different areas.

We observed staff following infection control policy, including handwashing and using personal protective equipment during their shift.

Seclusion room

This core service did not have a seclusion room. If a patient needed to be nursed in seclusion, the service could use seclusion rooms in other parts of the hospital.

Clinic room and equipment

Clinic rooms were equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. As the room was small, some equipment had to be used that was off the ward in the main hospital, such as a couch for physical examination and weighing scales.

We reviewed clinic room audits, which showed that staff checked, maintained, and cleaned equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers accurately

calculated and reviewed the number and grade of nurses and health care support workers for each shift.

The ward manager could adjust staffing levels according to the needs of the patients.

The rehabilitation service minimum safe staffing level was one registered nurse and three health care support workers during the day, and one registered nurse and one health care support worker at night.

Due to the nature of the ward, there were enough staff to carry out low-level interventions. Data showed that staff had mainly used only low-level interventions in the last 12 months. The ward manager was not included in staff numbers and provided additional support as required. Additional staff were provided to support increased activity levels, such as group trips, or in situations that required more staff, such as restraint or an emergency.

During the 12 months before this inspection, there had been no occasions where the hospital had not met the staffing levels for the rehabilitation service. All shifts were filled by either bank staff or overtime. No agency staff had been used. We reviewed staff rotas that confirmed this.

Long stay or rehabilitation mental health wards for working age adults

Good

The service had low vacancy rates. There were vacancies for one registered nurse post and 0.3 whole time equivalent health care support worker post. Two posts were over-filled by 100%.

Managers limited their use of bank staff and requested staff familiar with the service. They made sure all bank staff had a full induction and understood the service before starting their shift. The ward manager also explained how staff new to the rehabilitation service were introduced and helped to become familiar with the service, including access to electronic systems.

The service had low turnover rates at 5% across the hospital. Managers supported staff who needed time off for ill health.

Patients had regular one-to-one sessions with their named nurse. They told us they rarely had their escorted leave or activities cancelled, even when the service was short staffed. The records we reviewed confirmed this.

The service had enough staff on each shift to carry out any physical interventions safely.

Additional staff could attend quickly if they were needed. Staff had received training to enable them to deal with any incidents effectively.

Staff shared key information to keep patients safe when handing over their care to others.

The handover records we reviewed contained detailed, relevant information about each patient,

including their physical and mental health and changes to their legal status. Any actions for

incoming shifts were noted, and staff signed to confirm that they had received the handover.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was 24-hour medical cover. At night, a rota operated across the corporate provider's regional sites. The provider did not use locum doctors as cover was provided by the regional team.

Mandatory training

Please also see 'Forensic inpatient or secure wards'. The figures provided related to the hospital and were not broken down by core service.

Most staff were up to date with all their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Long stay or rehabilitation mental health wards for working age adults

Good

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff 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 and patients participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient prior to and on admission, using recognised tools, and reviewed them regularly, including after any incident. The records we reviewed all contained up to date risk assessments that had been reviewed regularly. Risk assessments included a baseline risk assessment on admission and a risk assessment for escort needs. Patients were involved in assessing their own risk, although some chose not to take part.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to, or posed by, patients. We reviewed three patients' care records in the rehabilitation service. All contained details of patients' individual risks and how they were managed and had been reviewed regularly.

Staff did not always follow policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Searching of patients returning from leave was decided using technology via a device at the entrance that randomly chose patients to be searched. All patients were aware of this, but this is not in line with the Mental Health Act Code of Practice.

The rehabilitation service was situated outside the secure perimeter of the main hospital. The ward was open, and all patients had access to outside space. Patients had their own mobile phones.

Some restrictions that applied across the hospital were related to risk, such as the limits on takeaway food as part of the healthy living and weight management strategies. Patients in this service all had unescorted leave but were encouraged to consider healthy options when buying food outside the hospital.

Use of restrictive interventions

Levels of restrictive interventions were low.

In the 12 months prior to this inspection, there were two incidents of the use of seclusion and two related restraints. No restraints were in the prone position. There were no incidences of segregation and no use of rapid tranquilisation.

Staff and patients participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service, including patient representatives, participated in the provider's reducing restrictive practice group, which met every quarter.

Staff 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. They understood the Mental Capacity Act definition of restraint and worked within it. Staff received training that enabled them to deal with any incidents appropriately.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. The provider had a comprehensive policy that set out guidance for staff.

Safeguarding

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.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their 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.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

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

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

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

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

Please also see 'Forensic inpatient or secure wards'.

We reviewed five patients' medicine records in the rehabilitation service. All were complete. All records had a consent to treatment form corresponded with their medicines. Two patients prescribed clozapine had regular physical health checks. Four patients were self-administering their own medicines. Three of these were fully self-administering their own medication. Staff had undertaken assessments to check patients were able to manage their medicines correctly and carried out random checks to check they were taking their medicines.

Long stay or rehabilitation mental health wards for working age adults

Good

Track record on safety

The service had a good track record on safety.

In the 12 months prior to this inspection, there had been no serious incidents and no never events within the rehabilitation service. A never event is a serious incident or mistake that should not happen if appropriate safety measures are in place.

Reporting incidents and learning from when things go wrong

The service 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.

Please also see 'Forensic inpatient or secure wards'.

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

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Please see 'Forensic inpatient or secure wards'.

We reviewed three patients' care records in the rehabilitation service. All were complete and up to date. They were comprehensive, reflecting patients' individual needs, such as their psychological, physical, social and cultural needs, and focused on patients' strengths and their awareness of their health. There was clear evidence of patients' involvement in their own care plans. Staff and patients reviewed and updated them together regularly and if there were any changes to patients' needs.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. They delivered care in line with best practice and national guidance (from relevant bodies e.g., the National Institute for Health Care and Excellence (NICE)).

Long stay or rehabilitation mental health wards for working age adults

Good

The multidisciplinary team provided a range of assessments, care and treatment such as psychological interventions, activities, education, training and work opportunities, to support patients build the skills needed when they left the hospital. They understood and followed best practice guidelines in formulating care and treatment. Clinical notes referenced national guidance and best practice.

Staff identified patients' physical health needs and recorded them in their care plans. They made sure patients had access to physical health care, including specialists as required.

Patients had good access to physical health care, including any specialist care they needed. There were two registered nurses who led on physical health care. They carried out regular physical health checks for all patients and advised ward staff about physical health needs. Monitoring included blood tests and checking the side effects of medication. Patients' care plans contained details of their physical health needs and how they were being addressed. Patients attended community health services such as dentists, chiropodists and GP surgeries for any physical health need.

Staff met patients' dietary needs, and they assessed those needing specialist care for nutrition and hydration.

Staff assessed patients' dietary needs and ensured they were treated. They referred patients to specialists if they needed to, for example, patients who had diabetes.

The provider had noted that many patients had a high body mass index, and some had high cholesterol levels. The provider had developed a healthy living and weight management strategy to address this. There was discussion with the patients' council and the physical health group, so that all were consulted and represented, and all disciplines were involved.

Many of the drinks and snacks in the shop on-site were sugar free and low fat.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

The weight management programme, 'mission fit', was facilitated by a fitness instructor, who led an educational programme about healthy living and encouraged participation in exercise sessions. The programme was aimed at service users in a mental health environment. It combined education about healthy living with exercise sessions.

'Mission fit' also had links with the local community and patients could access local gyms. This helped establish physical activity as part of patients' recovery into the community.

The provider also offered a range of health promoting activities, such as walking, cycling, healthy eating, access to the gym and a weight management programme.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

The multidisciplinary team used various recognised tools to provide an overview of patients' progress through care and treatment. Some patients were using recognised tools to help them measure their progress and staff also used patient reported outcomes relating to treatment and side effects of medicines.

Staff used technology to support patients.

They used an electronic care recording system and there were electronic dashboards that staff used to monitor patients' health.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Staff were involved in a range of audits, such as monitoring completion and reviews of care plans. Audits were recorded on the electronic dashboards and informed the senior management team during the morning handover meeting.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the 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.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The multidisciplinary team included medical and nursing staff, social workers, occupational therapy, speech and language therapy and psychology staff. Patients went into the community to visit other specialists such as physiotherapy, chiropody or a dietician if they needed to. All patients were registered with a GP and a dentist.

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. On-going progression of skills, knowledge and ability was considered fundamental to maintaining quality care. Managers encouraged staff to develop new skills and share best practice. The staff we spoke with were positive about the support they received and the opportunities for progression that they had access to. They received protected time for learning and development.

Managers gave each new member of staff a full induction to the service before they started work.

All staff had a comprehensive, eight-week induction that included the provider's supporting culture and values, collaborative approach, processes, mandatory training, and a ward-based induction.

Managers supported staff through regular, constructive supervision and appraisal of their work. Supervision and appraisal rates across the hospital were compliant with the provider's targets at 95% and 94% respectively. Staff could request more supervision if they wanted it.

The provider's values underpinned supervision and appraisal and the staff we spoke with had a good understanding of them. Sessions included discussion of practice and performance, case management, support and professional development. Staff also had reflective practice sessions led by the psychology team.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Staff meetings took place every month and staff could raise any concerns or any issues they had. The meeting notes were available to all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They made sure staff received any specialist training for their role.

Long stay or rehabilitation mental health wards for working age adults

Good

With staff, managers identified learning needs during supervision and appraisal, including those arising from challenges they came across in their practice. There were opportunities for learning and sharing across the service, including reflective practice meetings, and managers made sure staff were able to develop their skills, knowledge and experience.

Managers recognised poor performance, could identify the reasons and dealt with these. They addressed performance concerns effectively and quickly, and they understood how to manage and support staff if their performance did not reflect the provider's vision and values. Managers discussed practice and performance with staff and encouraged them to reflect. They described the procedures they followed and how they were supported if they had to deal with performance issues.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Please also see 'Forensic inpatient or secure wards'.

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

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

Please also see 'Forensic inpatient or secure wards'.

Good practice in applying the Mental Capacity Act

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

Please also see 'Forensic inpatient or secure wards'.

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

Good

We did not rate this core service at the last inspection.

At this inspection we rated caring as good.

Long stay or rehabilitation mental health wards for working age adults

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They 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 were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

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

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

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.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

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

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff helped families to give feedback on the service.

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

Please also see 'Forensic inpatient or secure wards'.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Good

We did not rate this core service at the last inspection.

At this inspection we rated responsive as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Care records contained details of activities the patients had undertaken and there was clear evidence of discharge planning.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

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

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

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient.

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

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care.

Please also see 'Forensic inpatient or secure wards'.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. There were no delayed discharges from the rehabilitation service.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

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

Please also see 'Forensic inpatient or secure wards'.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

The rehabilitation service had a ward and a separate self-contained area that one patient was using prior to discharge. On the ward, there were open plan communal areas, including bathrooms, space for activity, a dining area and a spacious kitchen, where patients could make drinks and snacks.

The furniture looked comfortable and well maintained. The communal bathrooms were clean and tidy.

Patients' artwork was also displayed around the communal areas.

Each patient had their own en-suite bedroom, which they could personalise, and which provided a secure place to store personal possessions. All patients had their own keys to their own en-suite bedrooms. The doors had vistamatic windows that patients could operate from inside. They had personalised their rooms with artwork, pictures and photographs.

Staff used a full range of rooms and equipment to support treatment and care. A choice of activities was available every day, such as drama, photography, music and educational opportunities. Patients could choose to do individual activities or as a group. They had their own schedule of activities and there were others open to them if they chose. There was a gym, sports hall and swimming pool on site, although staff encouraged patients to use community facilities if they wished. We saw some patients going out to use community sports facilities.

The service had quiet areas and there was a room away from the ward where patients could meet with visitors in private.

Patients could make phone calls in private. They had their own mobile telephones and told us they could use them their bedrooms for privacy.

The service had an outside space that patients could access easily. The ward opened directly onto a well-maintained, spacious garden area, where patients grew vegetables and plants.

Patients could make their own hot drinks and snacks and were not dependent on staff. The kitchen was open and patients each had their own lockers to store non-perishable food items.

The service offered a variety of good quality food. The provider regularly sought feedback about food, such as at ward community meetings and patients' council meetings.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients in the rehabilitation service told us the food was good and healthy.

Patients each received a weekly budget for food. Meals were agreed in advance and a rota in the kitchen showed which tasks patients had agreed. Those who were self-catering budgeted, shopped and cooked independently, with appropriate support from staff if they needed it.

Patients' engagement with the wider community

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

They supported patients and made sure they had access to opportunities for education and work. They helped patients to stay in contact with their families and carers, and they encouraged patients to develop and maintain relationships both in the service and the wider community.

Staff ensured that care was person-centred and met each patient's needs. They understood how meaningful activity was essential to recovery. They also encouraged patients to develop their skills and independence through taking up opportunities outside the hospital.

There was a range of opportunities for work and education both on site and outside the hospital, and staff encouraged patients to make use of community amenities. Patients had enough leave to enable them to take part in life in the wider community, which helped them develop their independence. They saw their experiences as positive and recovery focused.

Staff also supported patients to continue their relationships with their friends and families. They facilitated visits, and patients could also use technology such as teams, which meant they could see the people they were talking with, to help maintain their relationships.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service had made adjustments for people with mobility issues, such as wide doorways and low height switches, and there were two bedrooms on the ground floor.

Please also see 'Forensic inpatient or secure wards'.

Listening to and learning from concerns and complaints

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

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.

Long stay or rehabilitation mental health wards for working age adults

Good

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

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Please also see 'Forensic inpatient or secure wards'.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Good

We did not rate this core service at the last inspection.

At this inspection we rated well led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff and patients knew who the leadership team were. Managers were committed to promoting improvement and they were aware of the priorities of the service.

Vision and strategy

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

They were committed to supporting patients to develop their independence. They made sure the service focused on recovery and motivation.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Long stay or rehabilitation mental health wards for working age adults

Good

The atmosphere at the hospital was calm and relaxed. Staff said they felt valued and respected, and that their managers were supportive. They told us the teams worked well together.

There were opportunities for staff to develop their abilities and experiences, such as gaining professional qualifications and a range of skills training was available.

Managers made efforts to ensure good staff welfare, such as massage sessions, wellbeing groups, counselling and support where needed.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance processes ensured that the service ran smoothly.

However, we found that a ligature audit was not dated, so it was not possible to see that it was current. This had not been picked up by the provider's governance systems. The provider's systems should identify when practice is not in accordance with policy so that issues can be addressed.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information.

There was a risk register dated June 2022 that included issues, control measures and details for resolution. Staff could submit issues for inclusion on the risk register. A copy was kept on the ward for easy access.

Managers used various sources to inform risk, including data, audit findings and information from meetings at ward level.

Information management

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

They used information available to help improvements in the service. The provider used electronic dashboards to collate data and support staff.

Engagement

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

Staff had developed local links to help support patients in the community, such as local charities, college and businesses.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients were involved in addressing issues and developments via community meetings and patients' council meetings. The provider asked patients and carers to complete a satisfaction survey every year, to understand their views.

Learning, continuous improvement and innovation

Managers used learning to inform improvements, and learning was shared across the hospital and between the providers other sites, such as from incidents, complaints and reviews.

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Requires Improvement

We did not rate this core service at the last inspection.

At this inspection we rated safe as requires improvement.

Safe and clean care environments

The wards were safe and clean. They were not all well furnished, well maintained or fit for purpose but there was a comprehensive plan of refurbishment in progress, due to be completed by January 2023.

A hospital-wide environment audit detailed the ongoing planned refurbishment on each ward. It included all bedrooms and communal areas, and detailed actions already taken, such as that new furniture had been ordered, and set completion dates. The most recent review was June 2022. The refurbishment programme was included in the provider's quality improvement plan and was expected to be completed by January 2023. Capital expenditure of £450,000.00 had been allocated for the refurbishments.

Some issues needing refurbishment impacted on patients, such as the small communal shower room. Patients told us that it leaked onto the communal corridor floor, and it didn't always preserve dignity.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. There was a map of the ward in the nurse's office which showed ligature points across the ward. The ward completed a monthly environmental ligature point audit which was completed by a health care support worker and reviewed by the ward manager and the health and safety team.

Staff could not observe patients in all parts of the wards, but they knew about any potential ligature anchor points and mitigated the risks to keep patients safe, such as with the use of mirrors and staff placement on corridors. All patients were observed by staff at least once every 15 minutes, using their observation processes and following patients' individual risk assessment of observation needs.

Acute wards for adults of working age and psychiatric intensive care units

Good

The ward complied with guidance and there was no mixed sex accommodation. The ward was for male patients only.

Staff had easy access to alarms and patients had easy access to nurse call systems. There were lockers in each building that staff could access when they moved across the hospital to access alarms specific to each ward.

Maintenance, cleanliness, and infection control

Ward areas were clean. However, they were not well maintained or fit for purpose.

There was a small, single shower room, which opened directly onto the communal hallway. This shower had nowhere to hang clothes or a towel and patients had to hang them on the main door, which would need to be opened to be able to get access to them. The shower was controlled by a sensor, and patients struggled to get changed or undressed in the room without the shower turning on. We spoke to three patients who all said the shower room was a concern, including that it leaked onto the communal corridor floor and that it wasn't dignified. There had been an incident in March 2022 when the shower room had flooded into the main corridor whilst in use by a patient and staff had to intervene.

The communal toilet and shower room was not of good repair, with the privacy film in the external facing window being partly scratched off and the floor coming away where it met the cupboards. Whilst interviewing the ward manager in their office, a noisy vent in the ceiling leaked water onto the desk.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed three months cleaning records and had a tour of the ward areas and saw cleaning was regularly undertaken and the environment was clean.

Staff followed their infection control policy, including handwashing. Staff also had COVID-19 procedures, which included changing face masks and washing hands when entering and leaving different parts of the hospital, such as from one ward to another.

Seclusion rooms

The ward had two seclusion rooms. One was located on the ward and the other was located downstairs off the ward. They both allowed clear observation and two-way communication. They had a toilet and a clock. However, the chairs for staff to sit on in the downstairs seclusion room were ripped and not in good condition.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

Acute wards for adults of working age and psychiatric intensive care units

Good

Managers accurately calculated and reviewed the number and grade of nurses and health care support workers for each shift. The service did not always have enough nursing staff. The ward required two qualified nurses and three to four health care support workers for a day shift and night shift. The number of health care support workers could change based on the observation needs of the patients on the ward. We reviewed five weeks rotas from June 2022. We found that five night shifts only had one qualified nurse on shift, which did not meet the requirement of two qualified nurses. Staffing was reviewed on the services risk register. There was no timeline included to state when actions were to be completed by, but the risk register had been reviewed by the clinical governance meeting in June 2022.

The service had low vacancy rates. There were vacancies for 1.2 whole time equivalent registered nurses and two whole time equivalent health care support workers on Hulton ward.

The service had used bank staff to cover 2721 shifts and agency staff to cover 279 shifts in the previous 12 months across the service. There were 282 shifts that had not been covered by bank or agency staff, and the provider told us that support was sought from other wards and departments during these times.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had a pool of regular bank staff who worked at the hospital regularly and knew the patients well.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The induction included a full key induction on arrival to The Spinney and then an induction to Hulton ward which included participation with the daily handover, review of patient care plans and orientation to the ward.

The service had low turnover rates. Turnover was 6% for the previous 12 months.

Managers supported staff who needed time off for ill health. Levels of sickness were low at 5% for the whole hospital.

The ward manager could adjust staffing levels according to the needs of the patients. Following our inspection, the ward had increased the number of health care support workers on shift for both day and night to ensure patients had the appropriate support available.

Patients had regular one to one sessions with their named nurse and this was recorded in patients care plans. Patients were allocated a second named nurse in case their own named nurse was not available. They also had a named health care support worker and a second one in case that person was not available.

Patients sometimes had their escorted leave or activities cancelled when the service was short staffed. Two patients told us their leave had been cancelled because there were not enough staff.

The service had enough staff on each shift to carry out any physical interventions safely. In June 2022, 92% of permanent staff and 83% of bank staff had completed training in managing violence and aggression.

Staff shared key information to keep patients safe when handing over their care to others. Handovers took place twice a day at the change of shift. The service kept detailed paper handover documents. Staff said the handover was comprehensive, and the Independent Mental Health Advocate also said they received a handover when attending the ward.

Medical staff

Acute wards for adults of working age and psychiatric intensive care units

Good

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was 24-hour medical cover. At night, a rota operated across the corporate provider's regional sites. The provider did not use locum doctors as cover was provided by the regional team.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Patient observation levels were increased in response to identified risks. The five care records we looked at had personalised plans to manage any patient risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff described how they knew when a patient's risk was escalating and how they would respond to this. Hulton ward also had an authorisation and control of high-risk items database which listed specific items and their accessibility on the ward. These items were considered high risk and could compromise security. The database described controls for those items that were inherent to the level of security across the hospital. Controls applied to visitors to the site as well as patients, including professional visitors. High risk items included mobile phones, items of food and drink, aluminium or metal containers, internet connective watches, laptops, i-pads and tablets. The database itself was not dated but the instructions explained how it could be reviewed and updated at any time by completing a risk assessment for high-risk items. The documents formed part of the policy for the authorisation and control of restricted items, which was reviewed annually.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us they completed a rub down search of patients and used a metal detector on admission. Staff were able to explain the different types of searches and the process for each.

Staff were not aware of blanket restrictions at the service and did not review them regularly. There were several blanket restrictions at the service, but we could not always see the rationale for these.

For example, the service's welcome pack stated that all parcels would need to be opened in front of staff. Patients had been involved in developing the welcome pack.

In the weekly community meeting minutes from March 2022 to June 2022 access to hot water was discussed twice, and food restrictions, such as access to takeaways and puddings, were discussed twice.

We talked to three patients who all talked about restrictive practice, including the number of times they could access fresh air, and that access to hot drinks was only available from 6:00 a.m. to 11:00 p.m.

These restrictions were not applied according to individual patient risk, which is not in line with the Mental Health Act Code of Practice.

The ward's blanket restrictions list referred to access to electronic disposable cigarettes and the colour-code system at the shop regarding food items the patients could buy. The Spinney's whole hospital blanket restrictions tool referred to a "blanket rules self-assessment audit" but this had not been completed on Hulton ward. Of the five care records we looked at, three did not specify any restrictions whilst the other two only listed a restriction on section 17 leave and one on seclusion.

Managers discussed and monitored risk daily at morning handover meetings, and the provider discussed risk and reducing restrictive interventions at their monthly clinical governance meetings and in June 2022 had stated that reducing blanket restrictions remained high on their agenda.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider complied with the guidance on implementing the Mental Health Units (Use of Force), Act, 2018. We looked at the provider's policy and practice to confirm this.

Staff 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. The ward had used restraint 797 times in the last 12 months. The hospital completed a monthly report of any floor restraint in prone (facedown) or supine (face up) positions and these were discussed at the monthly clinical governance meeting. There had been 59 restraints in the prone position in the last 12 months.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff discussed patient capacity often whilst we were on site; however, the service told us that patients at the service were not subject to the Mental Capacity Act, and they did not complete an audit to ensure it was being correctly applied. The Mental Capacity Act is in relation to a person's capacity to make a particular decision.

Staff did not always follow the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation (medicine given to manage aggression or agitation). Hulton ward had used rapid tranquilisation 43 times from 28 June 2021 to 28 June 2022, relating to three patients. NICE guidance states that people given rapid tranquilisation should be monitored at least every hour until there are no concerns about their physical health. We

reviewed a sample of restraint records and found that patients did not always have physical observations taken, and if the patient declined there was no record of repeated attempts by the staff to ensure these were taken. However, two of the three records did state that visual observations of physical health were taken instead. Two records did not contain a record of the doctor's review following the treatment, or a record of a debrief with the patient.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Hulton ward had secluded 16 people 34 times from 28 June 2021 to 28 June 2022. The records we reviewed documented a clear rationale for the seclusion and regular nursing and doctor reviews at the appropriate intervals and discussion about the seclusion at multidisciplinary meetings and with the patients.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. At the time of our inspection there were no patients in long-term segregation, but the hospital had a policy that provided guidance for staff. Hulton ward had used long-term segregation five times from 28 June 2021 to 28 June 2022. The Independent Mental Health Advocate told us that the service would always keep them informed of any patients in seclusion or long-term segregation. The service sent us a completed Mental Health Act audit; this was not dated but they told us it had been completed in August 2021.

Safeguarding

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.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

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

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

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily.

(Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete)

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the prescription charts for all patients on the ward and saw that medications were discussed regularly in the weekly ward round.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The three patients we spoke with said they saw the doctor weekly at ward round and were involved in discussions about their medication. The carer we spoke with said they were informed about their relatives' medications and received a phone call after every ward round on a weekly basis. Staff told us they would access easy read documents if patients requested them.

Staff completed medicines records accurately and kept them up to date. The ward had a weekly visit from a community pharmacist who would advise the ward manager of any concerns using an online pharmacy system. However, staff told us that the pharmacist did not consistently visit the ward and the inconsistency of visits had been noted at the service's June 2022 clinical governance meeting. The provider had expressed concerns with the pharmacy service about this not taking place as contracted. However, the wards continued with their own weekly clinic and medication audits so that oversight was maintained.

Staff mainly stored and managed all medicines and prescribing documents safely. However, we found that one medication was two months out of date and that fridge temperatures had not been taken once in May 2022 and three times in April 2022. The medication was disposed of at the time it was found.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff completed a reconciliation of medications on admission of a patient and all medications were reviewed by the doctor.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff on the ward said they regularly reviewed patient medicines at the weekly ward round, and they had regard for guidance about stopping over-medication of people with a learning disability, autism or both, known as STOMP. The prescription charts we reviewed confirmed that patients were only prescribed medications when appropriate.

Staff did not always review the effects of each patient's medicines on their physical health according to NICE guidance. We found one patient was on a drug that was 50% higher than the British National Formulary limit but no physical health checks had been completed since prescribing in March 2022. We raised this with the provider who advised the patient had always declined. Following our conversation, the patient agreed to these checks and a contingency was put in place should the patient continue to decline these checks going forward. We reviewed three rapid tranquilisation (medicine given to manage aggression or agitation) records and found two did not have a doctor's review recorded afterwards.

Track record on safety

Acute wards for adults of working age and psychiatric intensive care units

Good

Please also see the forensic inpatient or secure wards.

Reporting incidents and learning from when things go wrong

Please also see the forensic inpatient or secure wards.

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Good

We did not rate this core service at the last inspection.

At this inspection we rated effective as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

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

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.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance (from relevant bodies, e.g., the National Institute for Health Care and Excellence (NICE)).

Staff identified patients' physical health needs and recorded them in their care plans.

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

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the 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.

The service had access to a full range of specialists to meet the needs of the patients on the ward.

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.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

(If relevant) Managers recruited, trained and supported volunteers to work with patients in the service.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

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

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

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

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

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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.

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

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Acute wards for adults of working age and psychiatric intensive care units

Good

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

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There were no deprivation of liberty safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Good

We did not rate this core service at the last inspection.

At this inspection we rated caring as good.

Acute wards for adults of working age and psychiatric intensive care units

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They 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 were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

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

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

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.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

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

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff supported, informed and involved families or carers.

Staff helped families to give feedback on the service.

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

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Good

We did not rate this core service at the last inspection.

At this inspection we rated responsive as good.

Access and discharge

Sometimes, patients did stay in hospital when they were well enough to leave due to lack of suitable beds in other areas; however, the service provided additional support to these patients.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. There had been two delayed discharges but the reasons for both were outside the provider's control.

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

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

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

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. There were two delayed discharges on the ward. Expected length of stay on the psychiatric intensive care unit was eight weeks, but one patient had been on the ward for 19 months and another patient for six months. Discharge was discussed at the patient's weekly ward round and within their care records. The delayed discharges were due to there not being appropriate hospital beds available for the patients to move to in their local area. The service supported patients who had been at the service for a long period of time with additional leave and offered additional support.

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff carefully planned patients' discharge; however, staff said there was a lack of suitable hospital beds in patients' local areas, which meant there were delayed discharges on the ward. Staff told us delayed discharge and discharging patients to the community was one of their biggest concerns, but they took positive risks to ensure each patient's care pathway was effective. There was a weekly meeting with ward managers where delayed discharge was reviewed.

Staff supported patients when they were referred or transferred between services and the service followed national standards for transfer. The ward had a discharge checklist to ensure all discharge activities were actioned and a discharge survey was sent to all discharged patients to complete. Pre-discharge meetings were held with everyone involved in the patients care and treatment.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward did not always support patients' privacy and dignity. Each patient had their own bedroom, and they could keep their personal belongings safe, but they did not have en-suite bathrooms. Patients could not make hot drinks at any time

Each patient had their own bedroom, which they could personalise, and they had a secure place in their bedrooms to store personal possessions. We toured the ward and looked at a sample of patient bedrooms and patients we spoke to confirmed this. Patients did not have en-suites and at the time of our inspection, seven patients shared one communal bathroom that had a shower and toilet, and another separate toilet and a separate shower room.

However, the ward had an additional three bedrooms and two bathrooms that had been for the sole use of one patient for the previous 13 months. This patient was discharged the day before we inspected. During our inspection, the service told us that these additional bathrooms had been refurbished and were accessible for all the patients on the ward.

Staff used a full range of rooms and equipment to support treatment and care. The hospital had outstanding facilities including a sports hall, a well-equipped gym, art and craft rooms, a games room, a music room with computers and a swimming pool. In the grounds, there was a sports track and a fishing lake. There was a physical healthcare suite, a therapy kitchen, and a shop where patients could purchase snacks, drinks, and electronic cigarettes. The patients on Hulton ward could have access to the additional facilities when risk assessed and authorised by the doctor.

The service had quiet areas and a room where patients could meet with visitors in private. The hospital had rooms off the ward around the hospital where patients could meet with visitors.

Patients could make phone calls in private. The ward had a telephone room with a payphone and patients could also make calls on their own mobile phones.

The service had an outside space that patients could not access easily. Patients could take three breaks for fresh air and four e-cigarette breaks a day. This was because the outside courtyard was not accessible without staff support and was shared with another ward.

Patients could make their own hot drinks and snacks and were not dependent on staff. However, there was a restriction on access to hot drinks and they were only available between 6am and 11pm. There was no document to state why these restrictions were in place or that the restrictions were reviewed regularly and individualised.

The service had an outside space that was shared with another ward in the forensic service. Due to being shared, use of the courtyard operated on a timetable. Each ward had dedicated times when they could use the area, and the provider had a policy on this that provided guidance for staff. Patients could take three breaks for fresh air and four e-cigarette breaks a day.

Although the service engaged with patients to try to improve the variety and quality of food, some patients were not happy with the variety of good quality food available. The hospital provided patients with a 3-week menu on rotation, which included a vegetarian option, a vegan option, and a Halal option. The patients selected their lunch and dinner choices each morning. Patients and staff told us the food was not of good quality. Community meeting minutes from January 2022 to June 2022 mentioned food concerns nine times from patients, including that food could be better, that there was not enough food, and asking for puddings and food other than sandwiches. One patient told us there needed to be more choice and larger portions. Staff said the food was not great and that patients could go weeks without a vegetable and all the options were chicken or non-hot options such as baguettes. We reviewed the menu and found three days where chicken-based meals were the only option for both lunch and dinner, with vegan and vegetarian substitutions.

Patients' engagement with the wider community

Staff supported patients with relationships outside the service but did not always ensure patients had access to activities.

Staff did not always support patients to do activities. The community meeting minutes from April 2022 to June 2022 discussed activities at the service, which included a walk around the hospital grounds, community leave and breakfast club, but there were some minutes where no meaningful activity was noted. We saw three community meeting minutes where patients had requested more activities. One patient said the limited access to ground leave was not enough and another patient said there was not enough to do. Staff told us patients needed more to do due to the length of time they were there but there were not enough staff to facilitate.

Staff helped patients to stay in contact with families and carers. Patients said their families were involved in their care and treatment and the carer we spoke to said they were regularly updated on their relative's care. One patient told us that when family visited, they were given additional time if the visit ran over the allotted time, whilst another patient told us their family were unable to visit due to the long distance between the hospital and their home. Patients also had access to their own mobile phones or the ward phone so they could contact family and friends directly.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. The ward had a weekly community meeting and getting along with each other was a regular agenda item.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Hulton ward was situated on the first floor of the building but had a lift that could be used for someone who required disabled access. The service said they would risk assess patients' needs and refer to a ground floor psychiatric intensive care unit if required.

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service kept a complaints book, and all complaints were reviewed by the ward manager and the service's complaints officer. There were notice boards on the ward that provided information to patients which included information about their rights and the contact details for the Independent Mental Health Advocate.

The service did not have information leaflets available on the ward in languages spoken by the patients and local community, but staff confirmed these would be made available where a patient required them.

Managers made sure staff and patients could get help from interpreters or signers when needed. The hospital had a process in place with an external translator and interpretation service.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room at the hospital which patients could access off the ward and items to support beliefs could be requested from the occupational therapy team.

Listening to and learning from concerns and complaints

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

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.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good

We did not rate this core service at the last inspection.

At this inspection we rated well led as good.

Acute wards for adults of working age and psychiatric intensive care units

Good

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Vision and strategy

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

All staff we spoke to could tell us the providers values.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Governance

Our findings from the other key questions demonstrated that governance processes mainly operated effectively at team level and that performance and risk were managed well.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The risk register was reviewed at quarterly clinical governance meetings, but it did not date each risk, so we could not see how long risks had been on the register. The safeguarding policies were not dated and did not have a review date. The latest Mental Health Act audit was also not dated, although the provider told us it was completed in August 2021.

Information management

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

Engagement

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

Learning, continuous improvement and innovation

The service had signed up to participate in the fourth cycle of the Quality Network for Psychiatric Intensive Care Units which was due to start later in the year.

Good

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

The wards were safe and clean. Not all the wards were well furnished, well maintained or fit for purpose but there was a comprehensive plan of refurbishment in progress due to be completed by January 2023.

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

We toured the ward areas and looked at some of the hospital's health and safety risk assessments, including fire evacuation procedures. We could see that staff had assessed and reduced the risk of fire, but we could not see that they had practiced periodic evacuation procedures in line with their policies and patients' personal emergency evacuation plans. Following the inspection, the provider implemented a new system of fire evacuation procedures in line with their policies, and they provided information to support this.

Environmental concerns were included in corporate checks and were reviewed at least every quarter. The latest review prior to this inspection was 14 June 2022.

Staff could not observe patients in all parts of the wards, but they mitigated the risks through patient observation, which they could increase according to patient need. Some corridors had mirrors to help staff see around corners, and each ward had a member of staff allocated each day to carry out security checks every hour, and more thorough checks twice per day.

The ward complied with guidance and there was no mixed sex accommodation. All the wards were male only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Patient bedrooms and communal bathrooms contained anti-ligature fittings to help reduce the risks of fixed ligature anchor points. The service had an up-to-date ligature risk audit and staff were aware of potential ligature anchor points.

Good

Forensic inpatient or secure wards

Staff had easy access to alarms, but on Lever ward patients did not have easy access to nurse call systems in the bathroom. Where patients had a known health condition, such as epilepsy, staff mitigated some of the risk by having a staff member outside the bathroom. There was also a sign in the bathroom advising patients with epilepsy to alert a member of staff if they wanted to use the bath.

Maintenance, cleanliness and infection control

The wards were clean, and some wards were well-furnished, but they were not always well maintained, or fit for purpose. All the patient kitchens we looked at needed refurbishment. For example, the laminate on the worktops was badly chipped exposing the chipboard underneath. Cupboard doors were chipped, scratched and discoloured. On Hesketh ward, the wardrobes in two of the patient bedrooms was similarly damaged and one of the shower trays was cracked, and the tiles and grouting were discoloured. The work surface of the computer room and patient kitchen on Rivington ward was damaged exposing the chipboard and, on some wards, some of the seating in patient lounges was torn.

On Hindsford ward, the treads on one of the internal stairways was worn and there was no handrail. There was no handrail on the small outside step in the patient garden area, and this could be hazardous for any patients with mobility difficulties. The provider had not carried out a suitable risk assessment on these areas.

A hospital-wide environment audit detailed the ongoing planned refurbishment on each ward. It included all bedrooms and communal areas, and detailed actions already taken, such as that new furniture had been ordered, and set completion dates. The most recent review was June 2022. The refurbishment programme was also included in the provider's quality improvement plan and was expected to be completed by January 2023. Capital expenditure of £450,000.00 had been allocated for the refurbishments.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. Staff also adhered to the provider's procedures for infection prevention and control by changing face masks when entering and leaving different parts of the hospital, such as from one ward to another.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. Patients had access to toilet facilities and could see a clock.

Clinic room and equipment

We checked the facilities on Hesketh, Pennington and Lever wards and found the clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff did not always check equipment, but mostly it was well-maintained, and cleaned. However, on Lever ward, we found two pieces of out-of-date medical equipment, a syringe and a nebuliser tube. Neither of these items were being used regularly with patients. Staff told us they would replace these items immediately after the inspection.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Good

Forensic inpatient or secure wards

Nursing staff

The service had enough nursing and support staff to keep patients safe. There were two nurses and four healthcare assistants on duty during the day and at night, there was one nurse and three healthcare assistants on duty per ward on each forensic secure ward. This did not include the ward managers who were qualified nurses. We checked staff rotas for the forensic wards and found that the actual staffing reflected planned numbers.

The service had low vacancy rates. Across the forensic wards, Hindsford ward had the highest number of vacancies at just under 8.5 whole time equivalent posts.

Across the hospital, there were 7.5 whole time equivalent vacancies for registered nurses out of 64.5 budgeted posts. Unregistered nursing posts were overfilled by 12.5 whole time equivalent staff, compared with 126 budgeted posts.

The service did not use agency nurses. All registered nurses were employed by the hospital. There were bank and agency health care support workers

Managers limited their use of bank and agency staff and requested staff familiar with the service. The bank staff worked at the hospital regularly and moved around the various wards wherever cover was required. The bank staff we spoke with had a good understanding of the patients on the forensic wards and knew them well. We looked at the provider's risk register to confirm that actions were in place to ensure that regular agency staff were used where possible. There was a comprehensive eight-week induction programme for all new staff, including bank staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Charge nurses took it in turns to act as site co-ordinators, ensuring that bank and agency staff received a thorough induction before starting work. We spoke with some bank staff who confirmed that this was routine practice if they worked on a ward they were not familiar with, or they had not worked on a ward for some time.

The service had low and reducing staff turnover rates. We looked at data to confirm that managers monitored staff turnover rates across the hospital. In June 2022, turnover was 6% for the previous 12 months, and the average length of service per staff member was over seven years.

Managers supported staff who needed time off for ill health. One member of staff had expressed appreciation for the support they received when off work.

Levels of sickness were low. The provider showed us data that confirmed the sickness absence rate for the hospital was 5%.

The ward manager could adjust staffing levels according to the needs of the patients. For example, if a patient required additional observations, managers could bring in additional staff. On the day of our visit to Hesketh ward, there were nine staff on duty during the day and this was because they had two new patients.

Patients had regular one to one sessions with their named nurse. We found evidence of this when we checked patients care records. The patients we spoke with confirmed that they had no difficulty getting time with their key workers.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Managers told us that some activities had been cancelled because of COVID-19, but that the activity programme was getting back to normal. Some patients said they occasionally had their leave re-arranged because of staffing shortages but this was rare.

Good

Forensic inpatient or secure wards

The service had enough staff on each shift to carry out any physical interventions safely. We looked at a sample of staff rotas to confirm that there were enough trained staff on each shift.

Staff shared key information to keep patients safe when handing over their care to others. We reviewed a sample of handover notes and found that they were very thorough and detailed. The healthcare assistants we spoke with confirmed that they received a detailed handover when they came on shift.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The forensic wards had four consultants and two junior doctors working full time during the day. There was 24-hour medical cover. At night, a rota operated across the corporate provider's regional sites. The provider did not use locum doctors as cover was provided by the regional team. Staff and patients told us they had no difficulty getting a doctor to attend the ward especially in an emergency.

Managers could call locums when they needed additional medical cover. The service did not have a need for locum doctors but, if they needed temporary cover, they could arrange for a doctor from the provider's regional team to support them.

Mandatory training

Staff were mostly up to date with their mandatory training. The provider collated data that showed compliance with mandatory training across the hospital was 96% for permanent staff and 93% for bank staff. The provider's target was 90%.

Of 31 training courses, there were three courses that fell below the provider's target of 90%. These were food safety level two, which was at 63% for eight permanent staff and 0% for bank staff (1 person), and the control of substances hazardous to health, which was at 64% for 25 permanent staff and 0% bank staff (1 person). The safe administration of medicines level two was 60% for five bank staff. However, all staff had completed training in safe administration of medicines level one, food safety level one training and health and safety. The provider had developed an action plan that would ensure compliance was rectified within one month of this inspection. Monitoring of mandatory training compliance was part of the provider's quality improvement plan.

The mandatory training programme was comprehensive and met the needs of patients and staff. Health care support workers completed the Care Certificate, which is a nationally recognised set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Staff completed training in working with people with a learning disability and/or autism that was appropriate for their role.

Managers monitored mandatory training and alerted staff when they needed to update their training. The system was automated and alerted staff when they needed to refresh their training. Ward managers had access to a dashboard and could check their team's compliance rates.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. However, we found some blanket restrictions were used that were not individually assessed and were not in line with the Mental Health Act Code of Practice. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Good

Forensic inpatient or secure wards

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We checked a sample of patient records on the wards we visited and found that all patients had up to date risk assessments in place, which staff reviewed routinely, and in response to incidents. Staff had two recognised risk assessment tools, one completed by medical staff and the other by the psychology team.

Staff recognised their responsibility and proactively managed risks. Patients were involved in identifying and assessing their own risk and staff discussed risk effectively with them. The multi-disciplinary team completed pre-admission assessments and all patients had an initial care plan that encompassed identified risks.

Staff used recognised risk assessment tools to develop comprehensive risk management plans that were used to understand and manage individual risks.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We saw examples where staff had increased patient observations in response to risks identified. We looked at care records and saw how staff had reduced risks by having appropriate management plans in place with individual patients.

For example, the provider bought all patients a takeaway meal once every quarter. This was part of the healthy living and weight management strategy, developed in response to many patients having a high body mass index and increasing cholesterol levels. Patients were encouraged to think about eating healthily if they bought takeaway food while they were on leave.

Staff identified and responded to any changes in risks to, or posed by, patients. The staff we spoke with could clearly tell us whether a patient's risk was escalating or decreasing. They changed levels of observation quickly in response to changes in risk behaviour. The staff and patients we spoke with told us they felt safe on the wards.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff searched patients randomly when they returned from unescorted leave and had access to a randomiser device to determine the frequency.

Some practices were not included in the restrictive interventions log as they were inherent to security or other strategy and were addressed elsewhere by policy, strategy or security measures, such as the healthy living and weight management strategy, or associated with the need for enhanced security. The reducing restrictive interventions group also discussed and reviewed these practices, such as the proposed introduction of smartphones in the forensic service.

The smartphone policy and protocol had been reviewed and the corporate provider had employed staff who could check devices. As a result, smartphones had been introduced on some forensic wards and some patients had had access to a smartphone since May 2022. Patients in the rehabilitation service and the psychiatric intensive care unit already had access.

The provider maintained a database of items that were considered high risk and could compromise security. The database described the controls for those items that were inherent to the levels of security across the hospital. Controls applied to visitors to the site as well as patients, including professional visitors. High risk items included mobile phones,

items of food and drink, aluminium or metal containers, internet connective watches, laptops, i-pads and tablets. The database itself was not dated but the instructions explained how it could be reviewed and updated at any time by completing a risk assessment for high-risk items. These documents formed part of the policy for the authorisation and control of restricted items, which was reviewed annually.

However, we found that on all wards all patients were required to open parcels in front of staff; this was was a blanket restriction that was not applied on individual patient risk and is not in line with the Mental Health Act Code of Practice.

The 'night state' protocol had been introduced as a security measure, following discussions with commissioners. This was under review, with commissioner involvement and a corresponding review of staffing levels to support and monitor response times to incidents, and was due to be completed by the end of August 2022.

Managers discussed and monitored risk daily at morning handover meetings, and risk was regularly discussed at clinical governance meetings.

Staff received accredited training in 'reinforce appropriate, implode disruptive' (RAID) methods of dealing with potentially aggressive situations. RAID is recognised in supporting patients to manage their behaviour, using positive approaches to interventions and reinforcing positive behaviours to reduce aggressive incidents.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff were trained to respond to violent or aggressive behaviour using a least restrictive approach. Patients told us staff rarely used physical restraint and staff confirmed that they tried to use lower-level restraints and guide patients wherever possible. if they did have to put hands on a patient, it was more to guide them. We observed staff interacting with patients and saw they were very skilled at verbal de-escalation. The provider monitored use of restrictive interventions, including seclusion, long term segregation and use of chemical restraint such as rapid tranquilisation. We looked at a recent audit of restraint data to confirm that staff used restrictive interventions only when necessary and for the shortest time possible.

The provider complied with the guidance on implementing the Mental Health Units (Use of Force), Act, 2018. We looked at the provider's policy and practice to confirm this. Patients and staff from the reducing restrictive interventions group had designed a patient-centred Mental Health Units (Use of Force) Act leaflet, and one patient had designed his version of restraint that was to be used on the front cover. There was also an easy read version of the leaflet. The provider also had a memorandum of agreement with the local police to support reporting crimes in or at the hospital, that complemented the use of force work. The memorandum also covered issues such as informal restorative justice. There were named officers who had visited the hospital, which had helped patients recognise that they could have positive relationships with the police.

Staff and patients participated in the provider's restrictive interventions reduction programme, which met best practice standards. We looked at some notes from the reducing restrictive interventions group and saw that patients and carers were involved, but the group started in April 2022, and they had not yet identified all the restrictive practices in place across the forensic wards.

The reducing restrictive interventions group, which was a hospital wide group, was part of the provider's quality improvement plan and positive risk-taking approach. It demonstrated the provider's commitment to reducing restrictive

interventions in an inclusive way that ensured patients and carers were engaged. The group had reconvened its meetings following the pandemic and met quarterly. We also reviewed minutes of clinical governance meetings that discussed the group's work, demonstrating how it fed into governance and was represented at corporate provider meetings via the national service user advisory group. This meant managers had good oversight of restrictive interventions and there was a process for the systematic, regular review of any restriction that was not an inherent part of ward security.

We observed a meeting of the reducing restrictive practices group during the inspection. Patient and carer representatives attended and took an active part in discussing restrictions. The group had developed a list of practices that patients thought were restrictive across the hospital. Each was reviewed in detail. The list was informed by data from quarterly audits carried out with patients on each ward.

The group also discussed and reviewed the monitored use of restrictive interventions across the site, including those which were not part of the log but were covered by policy, strategy or security measures.

We noted that physical intervention training was accredited and compliant with the Restraint Reduction Network training standards, under the Mental Health Units (Use of Force) Act 2018. The Restraint Reduction Network is an independent body that brings together committed organisations providing education, health and social care services to reduce reliance on restrictive practices.

Staff 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. We looked at a sample of restraint records that showed staff only used restraint where necessary and even then, for the shortest time possible.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff were taught that restraint had to be proportionate and justified and we spoke with several staff to confirm this.

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff rarely used rapid tranquilisation with patients, and when they did, they ensured appropriate health monitoring was in place following this.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We checked a sample of seclusion records to confirm this. The records we looked at were clear and well documented, with regular nursing and doctor reviews having taken place at the right times.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. At the time of our inspection, there were no patients in long term segregation, but the hospital had a policy that provided guidance for staff. We spoke with the independent mental health advocate who confirmed that staff would let them know if a patient was in seclusion or segregation.

Safeguarding

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.

Staff received training on how to recognise and report abuse, appropriate for their role. They kept up to date with their safeguarding training. All staff received training in safeguarding adults and children.

Good

Forensic inpatient or secure wards

The provider showed us data to evidence that 90% of permanent staff and 100% of bank staff were compliant with their mandatory training in safeguarding. Some permanent staff completed level two safeguarding training and compliance was 100%.

Compliance with level three training in safeguarding was 90% for permanent staff and 86% for bank staff.

Staff were also trained in Prevent to safeguard vulnerable people from being radicalised.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff received mandatory training in equality and diversity, and they encouraged patients to report any concerns to them.

Staff were observant of behaviour and interactions in order to identify abuse at an early stage, and they were proactive in taking action to prevent abuse or discrimination that might cause avoidable harm. They responded appropriately to allegations or signs of abuse, and they described how they ensured patients were protected.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had its own social work team to support staff, and they liaised regularly with the local authority adult and child protection teams. We saw examples in care records of staff working with public protection agencies to manage the risks posed by some patients at risk of re-offending.

Staff followed clear procedures to keep children visiting the ward safe. The hospital had a visitors' room away from the wards. The social work team carried out a risk assessment if there were children involved and staff always observed these visits.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider engaged with relevant organisations, such as the local safeguarding authority, to implement protective measures.

We looked at safeguarding records to confirm that staff made appropriate referrals to the local authority, who provided on-going guidance in regular meetings with the social work team.

Safeguarding included managing concerns about people in positions of trust, and any concerns raised about staff were addressed appropriately.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. We spoke with nurses, health care support workers and bank staff to confirm this. We also looked at a sample of records to check daily notes were thorough and contemporaneous.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff across the hospital used the same systems to record patient care and could access the electronic notes of any patient they needed to.

Records were stored securely. Care records were stored electronically with the appropriate security and permissions in place. Medicines records were stored securely in locked clinic rooms.

Good

Forensic inpatient or secure wards

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We observed a ward round and looked at care records to confirm that medical staff reviewed the patient's medicines regularly. All the patients we spoke with confirmed they could speak with a doctor easily to get advice about their medicines, and one carer told us they got leaflets about their relative's medicine, including side effects.

Staff completed medicines records accurately and kept them up to date. We checked individual patient medicines records to confirm this. Staff carried out weekly clinic and medication audits. The provider had a contract with an external pharmacy service that checked medicines every week, identified any concerns and ensured medicines management was safe.

Staff stored and managed all medicines and prescribing documents safely. We checked the storage arrangements on all the wards we visited and saw that staff managed medicines safely and in line with the provider's policy.

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

Staff learned from safety alerts and incidents to improve practice. Staff stored safety alerts separately in clinic rooms. There were low numbers of medicine errors on the wards but when there were, they were discussed in the managers handover each morning. We observed one of these handovers and saw that all managers from all wards across the hospital attended to discuss any incidents with a view to improving practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed staff practice in this area and found that they prescribed medicines only when patients really needed them and this included medicines that were 'pro re nata', which means 'as and when needed'.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. All patients had a physical health care plan in place and those prescribed certain medicines, such as clozapine, had their health routinely monitored by staff. We looked at care records and saw that staff used a colour coding system to identify whether patients allowed staff to monitor their bloods or not.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service 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.

Good

Forensic inpatient or secure wards

Staff knew what incidents to report and how to report them. All the staff we spoke with felt confident to recognise and report incidents, including near misses. They received guidance in how to make reports using the hospital's electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with the provider's policy. Managers checked that any incidents in the preceding 24 hours had been reported correctly when they met for their daily handover meeting.

Staff reported serious incidents clearly and in line with hospital policy. We checked serious incident documentation and spoke to managers to confirm this. Appropriate incidents were reported to the Strategic Executive Information System.

Staff understood the duty of candour. They were open and transparent, and they gave patients and families a full explanation if things went wrong. The provider had a specific policy in place. We looked at complaints data and spoke with staff to confirm that staff wrote to patients and, where appropriate, their carers when there had been incidents that caused serious harm.

Managers debriefed and supported staff after any serious incident. We spoke with staff who confirmed that senior nursing staff supported and debriefed staff. Staff could request a reflective session with psychology, where needed.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations, where appropriate. In our review of incidents, we saw that a patient had been interviewed and been provided with feedback in one incident investigation. A corporate review of incidents at the Spinney had noted that actions from investigations completed were embedded quickly.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff confirmed they discussed incidents at regular handover meetings. Hospital managers circulated regular bulletins containing details of lessons learned and staff had to verify that they had read it.

Staff met to discuss the feedback and look at improvements to patient care. We looked at a sample of team meeting minutes and saw that staff discussed incidents and improvements. Managers met each morning and identified opportunities for improving patient care.

There was evidence that changes had been made as a result of feedback. Staff told us that health care support workers carried wireless radios to summon medical assistance as a result of an incident that had happened while staff were on enhanced observations with a patient at night.

The service had zero never events in the 12 months prior to our inspection.

Are Forensic inpatient or secure wards effective?

Good

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

Good

Forensic inpatient or secure wards

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We looked at a sample of patient care records to confirm that patients had a thorough assessment of their mental health carried out by the multidisciplinary team.

Staff also carried out assessments of quality of life and physical health, and the impact of their environment on patients. They used recognised rating scales to assess and record severity and outcomes. They also used patient reported outcomes to help them assess the effects of treatment and side effects of medicines.

The psychology team offered a range of evidence-based, recovery focused interventions, which took place in groups and one-to-one individualised sessions, including, for example, neuropsychological assessments, assessments related to violence, sexual behaviour, anxiety, depression and personality disorder, and cognitive functioning methods. Patients were involved in developing their own programme of interventions.

The occupational therapy team emphasised building practical, purposeful skills. They provided a comprehensive range of activities in conjunction with assessments.

Assessments were designed to provide an overview of the individual's level of functioning, promote independence and develop their skills. Assessment included cognitive skills, practical skills such as cooking, cleaning, community skills and sensory and physical needs. The team also facilitated access to community experiences, such as physical activity, vocational opportunities, real work positions, social activities and education.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The hospital employed two physical healthcare staff that assessed all patients on admission. The physical healthcare nurses made sure staff monitored patients' physical health regularly and they themselves carried out six monthly health checks with all patients. We saw strong evidence in patient care records that appropriate physical healthcare monitoring was in place for all patients, not just those with health conditions that required it.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We looked at a sample of care records to confirm that patients had a variety of care plans in place that were tailored to their individual needs. All patients had a physical and mental health care plan as minimum, and some patients had up to 12 care plans. All patients on Lever ward, the ward for people with learning disabilities, had a specific learning disability care plan.

Staff regularly reviewed and updated care plans when patients' needs changed. Ten out of the 11 care records reviewed had up to date care plans. One care plan had missed one review on Hesketh ward, but there was no impact on the patient's care.

Care plans were personalised, holistic and recovery orientated. All patients had a positive behaviour support plan that staff had developed jointly with them. All care plans we looked at were holistic, which meant they covered the physical, mental, spiritual and social needs of each patient.

Good

Forensic inpatient or secure wards

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. We saw in care records and by speaking with staff, that patients were offered a variety of evidence based pharmacological, psychological, social and educational interventions that optimised their recovery. Relevant patients were offered targeted individual interventions to address areas such as substance misuse and offending behaviour. Therapy was offered in group sessions or for individuals, in order to meet their specific needs.

There was a strong focus on recovery, to encourage and empower patients to be able to manage their mental health and develop the skills they needed for life in the community, by ensuring they were central in planning their care. Care plans reflected this. They identified the outcomes for patients' needs and the treatments needed to achieve those outcomes, such as medicines, activities, education, psychological therapies and activities, and education, training and work opportunities to encourage patients to achieve independent living skills and establish them as essential to recovery.

Education was both internal and at local colleges. It supported patients in gaining qualifications, maintaining skills, using their interests to build literacy and numeracy skills, and learning foreign languages.

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g., the National Institute for Health and Care Excellence (NICE)). The hospital adhered to the standards set out by the Royal College of Psychiatrists. Staff understood and followed best practice guidelines in formulating care and treatment. Formulation is the process of facilitating a group of professionals to develop a shared understanding of a patient's issues, which forms the basis of the multidisciplinary team's intervention plan. It also allows space for staff to understand and process their own feelings. We saw in care notes reference to NICE guidance for specific interventions.

Staff identified patients' physical health needs and recorded them in their care plans. The physical healthcare nurses made sure all patients had a physical health care plan in place and all patients on Lever ward had an up-to-date annual health check in place.

Staff carried out therapeutic drug monitoring for patients prescribed medicines such as clozapine, to ensure their physical wellbeing, and physical health observations were carried out following rapid tranquilisation.

Staff made sure patients had access to physical health care, including specialists as required Patients with physical health conditions, for example, diabetes, were seen by an external specialist team for their annual review. We saw other examples in care records of how staff referred patients to specialists including respiratory and thyroid clinics.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients with dietary needs had specific care plans in place and had been referred to a dietician where needed. Staff confirmed they used food and fluid charts with patients that required this. We saw a positive example of how staff were supporting a patient with eating solid food.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The provider's proactive approach to healthy living and weight management ensured that staff were consistent in supporting people to live healthier lives, including identifying those who needed extra support.

The hospital had a range of healthy living initiatives, and they employed a member of staff specifically to help patients improve their physical fitness. The occupational therapy department provided guidance to patients about portion size and calorie intake. All the items in the shop were calorie counted and colour-coded to help patients make healthier choices about snacks and drinks. Patients were offered support and nicotine replacement therapy for help with quitting smoking.

We noted in clinical governance meeting minutes that many patients had a high body mass index. This was considered a high-level risk. Some were found to be rising following monitoring, and some patients' cholesterol was also rising. There was discussion at the clinical governance meetings around developing a healthy living and weight management strategy to manage this risk. This included consideration of menus and portion sizes, exercise and the foods patients were buying when on community leave or in the patients' shop. Some medicines were contributory. There was also discussion about least restrictive practice and the provider's duty of care towards the patients. There was further discussion with the patients' council and the physical health group, so that all were consulted and represented, and all disciplines were involved. The physical health group was asked to look at education for both patients and staff. Patients' council minutes that we looked at noted that patients who chose to buy takeaway meals while they were on leave were asked to have regard to healthy eating. The limit on takeaway food was part of the strategy to improve health. Weight management was also included in the quality improvement plan.

There was a weight management programme called 'mission fit' that educated patients about living a healthy lifestyle. The programme was led by a physical health and wellbeing coach. It included exercise sessions, such as walking, swimming, gym sessions, cycling and football, and discussion about healthy living, such as healthy eating, nutrition information and activity. This was in addition to the regular gym, swimming and multiple sports sessions running every week.

The programme was designed to build motivation, encourage participation and overcome negative symptoms of mental ill health. The hospital had exceptional facilities on site, and the programme also had excellent community links so patients could access activities away from the hospital. This supported mental and physical health and helped establish physical activity and healthy living as integral to recovery.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. When reviewing care records, we saw evidence of recognised tools being used with patients to monitor medication induced side effects. Appropriate patients were screened for malnutrition and outcome scales were used to measure health and social care outcomes. Staff used other tools to assess patients' level of risk of aggression and violence, and the likelihood of responding well to treatment. They also used patient reported outcomes to help them assess the effects of treatment and side effects of medicines.

They shared information about the effectiveness of interventions and used it to improve care and treatment and patients' outcomes.

Staff used technology to support patients. Patients had appropriate access to lap top computers they could use on the wards, and some had been provided with wristwatch fitness trackers so they could record and compare their physical activity. Most patients without unescorted community leave had supervised internet sessions. This was predominantly to manage individual risk, but on Lever ward it was also as a supportive measure.

Good

Forensic inpatient or secure wards

Staff used an electronic care recording system and there were electronic dashboards that they used to monitor patients' health. Incidents were recorded electronically.

The dashboards were used widely to monitor service delivery. They included patients' experiences, the care pathway and physical health care. They also recorded, for example, care plan reviews, risk assessments and outcome measures.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, staff were involved in thematic reviews and other initiatives aimed at improving the quality of care for patients. The service regularly contributed to the prescribing observatory for mental health, a Royal College of Psychiatrists initiative to improve prescribing practice.

Managers reviewed and addressed any issues from audits through clinical governance meetings.

Managers used results from audits to make improvements. For example, we looked at a search audit of the forensic wards where staff identified that patients did not have an individual search frequency assessment as per the provider's policy. When they repeated this audit, they found there was a vast improvement and most patients had them in place.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the 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.

The service had a full range of specialists to meet the needs of the patients on the ward. In addition to medical and nursing staff, the hospital employed health care support workers, occupational therapists, activity coordinators, psychologists, social workers and a speech and language therapist. The hospital was looking to employ a dedicated dietician but, in the meantime, a dietician visited the hospital regularly. Other specialists held regular clinics at the hospital including a physiotherapist and a chiropodist.

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, to ensure patients received care and treatment that optimised their recovery. Preceptorship nurses were enrolled in the corporate preceptorship academy, which supported them through the first year of practice. It also offered access to other training and networking events.

Staff told us they received good support and encouragement to develop their skills. There were opportunities for learning that meant they were able to develop their careers, including into management and leadership. They had protected time for learning.

Bank and agency staff received the same mandatory training as substantive staff and managers checked that agency staff had undertaken the appropriate level of training before starting their shift.

Staff on Lever ward received appropriate training in working with people with learning disabilities and autism, and the manager was an experienced learning disability nurse. Managers on other wards were experienced mental health nurses, supported by two experienced clinical managers.

Managers gave each new member of staff a full induction to the service before they started work. We spoke with some bank and agency staff to confirm that they always had a full structured induction before starting on a new ward. This included ensuring they had completed all essential training, such as the prevention and management of violence and aggression.

Managers supported staff through regular, constructive appraisals of their work. The hospital supplied us with data to show that 94% of staff across the hospital were up to date with their annual appraisal.

Managers supported staff through regular, constructive clinical supervision of their work. The hospital supplied us with data to show that 95% of staff were compliant with their supervision requirements. All the staff we spoke with told us they received regular clinical and line management supervision and could request additional sessions if needed. We looked at a sample of team meeting minutes and saw that staff also had access to reflective supervision facilitated by the psychologist.

Medical staff told us they were well supported and received robust supervision from the medical director.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We looked at a sample of team meeting minutes from across the medium and low secure wards to confirm that staff met monthly for team meetings. The notes were circulated to relevant staff including those that could not attend in person. Since the outbreak of COVID-19, meetings had been held virtually.

Senior managers provided cover on the wards so that staff could attend team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We spoke with a range of staff who told us they discussed training needs in supervision and had support to develop their skills. For professionally qualified staff, this included protected time for continuous professional development.

Managers made sure staff received any specialist training for their role. We spoke with staff who confirmed that they received additional training to carry out specific duties. For example, health care support workers received training and guidance to fulfil the security role on the ward and nursing staff took part in competence-based medicines management training to assist patients to self-administer. Staff also had access to other specialist training including alcohol and drugs awareness, child and adolescent mental health training and dialectical behaviour therapy.

Staff received accredited training in ‘reinforce appropriate, implode disruptive’ (RAID) methods of dealing with potentially aggressive situations.

The speech and language therapist provided training to staff, and the psychology department also offered a range of training to help staff support patients, such as self-harm and suicide assessment, group work skills, motivating patients to engage and learning disability training. The psychology department also facilitated ward-based reflective practice meetings that provided opportunities for learning and sharing across the service.

The provider supported staff to acquire the skills they needed to develop a personalised, enhanced programme of specialist care to meet the specific needs of a young patient whose presentation was outside their usual expertise. The

provider had agreed to admit a young person to the hospital when commissioners had been unable to find a suitable placement elsewhere, and they ensured staff had appropriate training so that they understood his needs and were able to provide a package of high quality, individualised care for this patient. Staff told us that they were always supported to enhance their practice so that care and treatment was improved.

Patients were also involved in training, so that attendees had the benefit of their perspective.

Managers recognised poor performance, could identify the reasons and dealt with these. They had access to a human resources department that could provide the necessary knowledge and guidance. We saw examples in governance meetings where managers had dealt with poor performance in an appropriate way, for example, through the disciplinary process.

Managers addressed concerns effectively when performance did not reflect the provider's vision and values, and they understood how to manage and support staff.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting and saw how staff from different disciplines worked together in a patient focussed way. Each member of the multidisciplinary team had input into patients' care plans. The physical health nurse and the speech and language therapist attended meetings when needed and requested by the team.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We looked at a sample of handover notes and spoke with staff about how they knew about changes to patients' care. The handover notes were very detailed and comprehensive. Care plans and daily notes were updated regularly so staff always knew what, if any changes had been made. Staff told us there was very good communication about patient care between the multidisciplinary team and staff on the wards.

Ward teams had effective working relationships with other teams in the organisation. We spoke with a range of staff to confirm that managers and staff worked effectively together to provide the right care and treatment for patients. For example, occupational therapy staff worked with nursing and support staff to ensure that patients could access activities both on and off the wards. Physical health staff worked with ward staff to ensure patients physical health was monitored as frequently as needed. Ward managers from across the hospital met with each other every weekday to discuss staffing, activities, appointments, incidents and the general running of the wards.

Ward teams had effective working relationships with external teams and organisations. Staff had effective relationships with the external advocacy service that visited patients on the wards every week. Staff encouraged patient advocates to attend ward rounds and other multidisciplinary meetings with the consent of the patient. Staff worked with public protection agencies, safeguarding teams and physical health specialists. Care co-ordinators attended multidisciplinary meetings including patient discharge meetings.

There were established relationships with other service providers, such as dentists and GPs, a barber and community services and groups. The connection with the local community was important to how care was planned, and patients' needs met. This included religious and ethnic background as well as their care and treatment.

Good

Forensic inpatient or secure wards

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

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

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The provider showed us data to evidence that the compliance rate for this training was 93% for permanent staff and 94% for bank staff.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The provider employed Mental Health Act administrators and staff knew when to ask them for support.

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 confirmed these were available for them on the hospital's intranet.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We spoke with patients and to the independent mental health advocate to confirm that staff provided good access to information about the advocacy service. There was suitable information on the ward, and we saw in care records that staff reminded patients at regular intervals about their rights to advocacy.

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. We checked a sample of patient notes to confirm this. Patients on Lever ward had access to easy read material about their rights.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.Staff facilitated patients to take leave and often supported them with excursions out of the hospital grounds. The patients we spoke with told us there was never any problem with them taking unescorted leave but occasionally, there was not always the staff available to escort patients, especially during COVID-19.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of this when we looked at consent documentation and medicines records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Each patient had a separate file where these were stored.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. We saw evidence of this when we looked at a sample of patient notes and multidisciplinary meetings notes.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We looked at an audit that confirmed this. We could not see evidence of the date it was carried out, but the provider told us it was completed in August 2021.

Good

Forensic inpatient or secure wards

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. The hospital provided us with data to show that 93% of permanent staff and 94% of bank staff were compliant with their mandatory training in this area. The staff we spoke with demonstrated a good understanding of the application of the Act in their day-to-day work with patients.

There were no deprivations of liberty safeguards in this service because all the patients were detained under the Mental Health Act.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence in care records how staff presumed the capacity of patients to make specific decisions. The speech and language therapist supported patients to communicate using pictures and easy read material.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples of this in patients' care records. Where staff could not identify a patient's nearest relative, they involved an independent mental capacity advocate, (IMCA). This is someone who can support and represent the patient in the decision-making process and ensure the Mental Capacity Act is being followed.

We did not see any examples of best interest decisions in practice, but staff assured us that the responsible clinician along with the multidisciplinary team would document these decisions in line with the hospital's policy.

The provider told us they did not monitor how well they followed the Mental Capacity Act through audits. However, we found no issues with this.

Are Forensic inpatient or secure wards caring?

Good

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They mostly understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Good

Forensic inpatient or secure wards

Staff were discreet, respectful, and responsive when caring for patients. We spoke with 11 patients and three carers from across the forensic secure wards. They all told us that most staff treated them respectfully and they were caring. A small number of patients said that some staff did not always knock on their bedroom doors before entering. Whilst on the ward, we observed many positive and caring interactions between staff and patients.

Staff gave patients help, emotional support and advice when they needed it. Patients confirmed that they had no difficulty getting hold of staff if they needed support and staff helped them with practical advice about a range of lifestyle issues as well as emotional support.

Staff supported patients to understand and manage their own care treatment or condition. We observed and we saw in care records that appropriate patients were assessed and supported to self-administer their own medicines. Patients reported they received advice about medicine side effects, and we saw in care records that patients were supported to manage their own health conditions, such as diabetes.

Staff directed patients to other services and supported them to access those services if they needed help. We saw in care records how staff supported patients to attend external appointments, like the dentist or other health clinics.

Patients said staff treated them well and behaved kindly. All the patients and the carers we spoke with told us that staff treated them with kindness, and this included ward managers who interacted with patients frequently.

Staff understood and respected the individual needs of each patient. They had a detailed knowledge of the needs of individual patients. They had taken time to get to know each patient's personal, cultural and social needs by reading about their history. Patients had support plans in place that provided staff with detailed information about their likes, dislikes, hobbies and interests.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All the staff we spoke with felt that they could raise concerns about this sort of behaviour towards patients.

Staff followed policy to keep patient information confidential. The service had confidentiality policies, which staff explained to patients. We looked at care records which showed evidence of staff sharing information with the appropriate consents. We did not see specific information sharing agreements so that staff could see at a glance who they could share information with; however, staff knew the patients very well and checked with them first before sharing any information with family and friends.

Involvement in care

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.

Involvement of patients

Staff usually introduced patients to the ward and the services as part of their admission. Each ward had a patient information booklet.

Staff involved patients and gave them access to their care planning and risk assessments. We confirmed this when we looked at patient records and spoke with patients. All patients had been asked if they wanted a copy of their care plan and this was recorded on their care notes. Most patients on Lever ward had copies of their care plans.

Good

Forensic inpatient or secure wards

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). On Lever ward, which was a ward for people with a learning disability, patients were given information in an easy read format, which met their assessed needs. The speech and language therapist visited the wards to help patients with communication needs.

Staff involved patients in decisions about the service, when appropriate. Patient participation was promoted and encouraged. Patients were involved in groups that gave them opportunity to put forward their views and thoughts on development.

The hospital had a patients' council that met monthly with hospital managers. Patient representatives from each ward attended to bring forward and discuss issues that had arisen from patient community meetings. The issues were then raised by the patients' council and discussed at clinical governance meetings.

Patients were invited to be involved in planning activities. They had designed and built a 'hope garden' in the hospital grounds and the idea had come from them. The garden conceptualised the stress felt during the pandemic and commemorated those lost. We spoke with patients who told us they had been involved in staff recruitment, although this had been paused due to the pandemic. They received training in interview techniques, so they could take part in shortlisting and interviewing new staff. Two patients commented that some of the forensic wards had been painted recently but they did not have a say in what colours were chosen; however, we saw in patients' council minutes that refurbishments across the hospital were discussed there, and patients were consulted.

Patients also had wider involvement via the corporate provider's service user national advisory group. A patient representative attended and fed back issues for discussion at the clinical governance meeting and the patients' council.

Patients were also involved in training, to offer their perspective.

Patients could give feedback on the service and their treatment and staff supported them to do this. We looked at a sample of community meeting minutes and found that patients were encouraged to provide feedback about a range of issues including the food, the environment and the facilities. The meeting notes were audited, and staff then completed 'you said, we did' sheets, or recorded actions in the ward community meetings book.

On most wards, there were 'you said, we did' sheets to show patients what had changed as a result of their feedback but on Hesketh ward, the sheets had not been filled in and on Lever ward, we did not see any sheets. Staff encouraged patients to give feedback on their care through ward rounds and by speaking with staff about anything there were not happy with. The provider also carried out an annual service user satisfaction survey, which we looked at. Most responses to the 2021 survey were positive and the feedback was good from those patients that took part.

Staff supported patients to make advanced decisions on their care. All patients were encouraged to complete an advance statement of their wishes and preferences. This is a statement about anything that is important to a patient in relation to their future treatment and wellbeing. We found that whilst all patients had been asked if they wanted to complete a statement, none of the statements had been reviewed. When a patient declined to make an advance statement, this decision had not been reviewed. Staff told us the hospital did not have any guidance about when these statements should be reviewed with patients.

Staff made sure patients could access advocacy services. We spoke with patients and with the independent mental health advocate to confirm that all patients were offered access to these services. Hospital managers provided the advocate with suitable space off the ward to see patients and staff were cooperative, with good communication about new and existing patients. The advocate also saw patients on the ward and attended ward rounds and other multidisciplinary meetings with them as requested.

The provider employed a patient recovery lead who worked with patients on every ward to support empowerment and involvement. The role included facilitating patients' council meetings and supporting patients to feed back to governance meetings. They had used teams so that external staff, such as those working at the corporate provider's head office, could join the meetings. They also facilitated ward community meetings, had supported the establishment of the takeaway nights and a food review group, and supported patients to develop the welcome pack and DVD.

The patient recovery lead also worked with patients to understand their perspective of security and their feelings about it. This work was enhanced by their involvement in the reviewing restrictive interventions group.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The provider valued carers' thoughts and experiences, and support for carers was robust so that they had opportunity to share their views. We saw in patient records that, where appropriate, staff involved families and carer's by inviting them to multidisciplinary meetings. We spoke with three carers, who felt very involved but said they had to ring the ward themselves when they wanted information. They did say, however, that they could always get through to staff and that they dealt with any needs they had.

If carers had, for example, mobility or financial issues that would prevent them from attending, the provider offered support to either fund their travel costs or provide transport for their journey.

Staff encouraged families to give feedback on the service. The provider carried out an annual survey for the hospital, which they sent out by email to carers. The survey asked for feedback on a range of issues such as the quality of care, visiting arrangements and how staff could support them to be involved in their relative's care. We reviewed the most recent survey and found that, for example, all respondents agreed that they could access carers' engagement opportunities and that they had received information about the service and how carers could be involved.

Staff gave carers information on how to find the carer's assessment. There was a carers' charter that included information about the services, the support available to them, and how to access a carer's assessment.

The provider had plans to resume the face-to-face carers' forum meetings and the carers' week, which had been suspended during the pandemic. These events provided support and facilitated understanding, learning and feedback for improvements in the service. The provider had made efforts to continue the meetings using technology, via teams. A newsletter was also sent out to carers. We looked at the editions sent out during the last two years and saw that they included topics such as the healthy living initiative and the reasons for changes, information about security measures, and positive actions, such as using technology to support families' involvement with patients. One patient had been able to take part in external meditation sessions with his family, using skype.

Carers were also involved in decisions about the service. They were represented at various meetings, and they were involved in governance, working collaboratively with the provider to drive improvement.

Good

Forensic inpatient or secure wards

Are Forensic inpatient or secure wards responsive?

Good

Our rating of responsive went down. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients usually did not have to stay in hospital when they were well enough to leave. Where discharge was delayed, this was due to factors outside the provider's control.

The provider had been asked to co-ordinate information about the model of care used in the hospital, to be disseminated across the corporate provider's locations.

Bed management

Managers monitored bed occupancy regularly. Staff managed access to beds at their weekly meeting which, involved managers, senior managers and members of the multidisciplinary team. Together they decided which patients to admit based on the needs of the patients and the dynamics of the existing cohort of patients.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of our inspection, the average length of stay on Shevington and Hesketh wards was much lower than on the other medium secure or low secure wards. Staff told us this was because patients tended to be admitted to these wards for assessment and then moved to other wards as needed.

The service did not always take patients from the local area and had a significant proportion of out-of-area placements. This was because they were offering secure services that might not be available in all parts of the country.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Staff had a pathway in place to move patients from medium to low secure wards as they progressed with their treatment. We saw examples where patients had been moved between wards with the same level of security because they were better suited to that environment or because there were safeguarding issues.

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

The hospital had a psychiatric intensive care unit on site that usually had a bed available if a patient needed more intensive care. If not, there were suitable facilities close by.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. In the 12 months prior to our inspection, the hospital had had two delayed discharges, on

Rivington and Lever wards. The reasons for the delay on both occasions were out of the provider's control; in one case a suitable placement could not be found that met the patient's needs and, regarding the other patient, the provider was waiting for a court decision. On Lever ward, one patient had had their discharge delayed for 248 days and on Rivington, a patient had had their discharge delayed by 322 days.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We saw from patient care records and multi-disciplinary notes that patients had discharge plans and discharge meetings took place with the involvement of relevant professionals.

Staff supported patients when they were referred or transferred between services. We saw examples in care records where staff accompanied patients to visit move on accommodation and other external placements.

The service followed national standards for transfer. Pre-discharge meetings were held with the receiving service and copies of care plans were sent to everyone identified in the plan as involved in the patient's ongoing care.

for people with

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom but not all had an en-suite bathroom. Patients could keep their personal belongings safe, and there were quiet areas for privacy. The food was of good quality, but patients complained about the amount and lack of choice. Patients could make hot drinks but could not always access snacks easily.

Each patient had their own bedroom, which they could personalise, and which provided a secure place to store personal possessions. We toured some of the wards and spoke to patients to confirm this. Patients' bedrooms had a set of lockable drawers and staff could store valuables in a secure place in the nurse's office.

The service had a full range of rooms and equipment to support treatment and care. The hospital had outstanding facilities including a sports hall, a well-equipped gym, a swimming pool, art and craft rooms, a games room, computers and a music room. In the grounds, there was a sports track and a fishing lake. There was a physical healthcare suite, a therapy kitchen and a shop where patients could purchase snacks, drinks and electronic cigarettes. In addition, wards also had some gym equipment.

Patients from all wards had been involved in the artwork around the site. There were paintings and drawings displayed on all the wards. There was a mural in the multi-faith room that patients had painted and plans to create another in the sports hall. The occupational therapy group sold some of their work at a Christmas market.

Patients did not always have access to snacks. On Lever ward, there was fresh fruit available for patients but on Hesketh ward, there was not. Managers had implemented a programme of healthier eating where patients were encouraged to limit unhealthy eating and snacking.

Patients could make their own hot and cold drinks, but some patients were dependent on staff for access to the kitchen because it was locked for safety reasons.

The service had quiet areas and a room where patients could meet with visitors in private. The hospital had a number of rooms off the wards which were used to facilitate visits with patients.

Patients could make phone calls in private. Patients had access to a ward phone in a private area and if this was out of use, they could use the ward cordless phone.

The service had outside space but not all patients could access it easily. Some patients on wards that were on the ground floor had access to outside space when they wanted it but, for example, on Hesketh ward, which was on an upper floor, patients could only take fresh air breaks at regular set times during the day and early evening. The patients on Lever ward shared their outside space with the psychiatric intensive care unit. Due to being shared, use of the courtyard operated on a timetable. Each ward had dedicated times when they could use the area, and the provider had a policy on this that provided guidance for staff. Some of the patients on the forensic wards were not permitted leave from the hospital, which meant having easy access to outside space was especially important to them. Some patients we spoke with told us they would have liked to have gone outside when they chose to and not just at set times. The provider had a risk assessment that addressed patients from different wards mixing outdoors.

Although the service engaged with patients to try to improve the variety and quality of food, there were issues with the variety of good quality food available. Nine of the 11 patients we spoke with told us there was too much chicken, not enough variety on the menu, and the portions were too small. We reviewed the menus and many meals had chicken and there were limited alternative options where patients did not like spicy foods. The provider had regularly sought patients' feedback about food, such as at ward community meetings and patient council meetings. Catering staff met with patients on the wards to discuss and review the menus and incorporate patients' choices and feedback.

We reviewed a recent patient survey and saw that out of 34 respondents, 31 thought that the meals provided offered choice and variety. One person did not agree or disagree. Thirty-one people also thought the meals catered for their dietary needs, including halal and vegetarian.

Patients had access to activities every day including at weekends. We spoke with patients and staff to confirm this, and the hospital provided us with a report to show how patients were involved in meaningful activity. Staff used electronic dashboards to monitor the hours of activity for each patient.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work and supported patients. Following appropriate assessments, patients could get involved in voluntary work either within the hospital or in the community with support from staff in the occupational therapy department. The hospital provided their own accredited training in functional skills so patients could gain a nationally recognised qualification. Staff had good links with local community groups and a small number of patients had been involved in paid work. Patients also had access to education and work-related opportunities, both at the hospital and in the community, which helped establish meaningful occupation as integral to recovery.

Staff helped patients to stay in contact with families and carers. We spoke with patients and staff who all confirmed that staff supported appropriate patients on regular visits to help them stay in touch with the people that were important to them. There was good use of technology, such as teams, that patients could use to keep in touch, especially when they were far away. Staff supported them to do so, and many had developed their skills during the pandemic.

Good

Forensic inpatient or secure wards

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients were encouraged to interact with each other in community meetings and they sometimes went on organised activities with staff outside the hospital. We saw examples in care records where patients were encouraged to keep in touch with their friends in the community.

Staff also supported patients to develop relationships with services in the community, to take responsibility for their own health and maintain their independence.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had some rooms which were accessible for patients with mobility issues. On Rivington ward, the provider had carried out significant building work to a patient's bedroom to make it more accessible. The occupational therapy department supported patients with any equipment or aids they might need, and the speech and language therapist ensured staff could support patients with communication. All the patients on Lever ward had care plans in easy-read format unless they did not want that.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. When we toured the wards, we observed that each ward had a patient notice board with information about their rights and how to complain. We observed how patients could speak with the ward manager if there was anything they were unhappy about. Staff gave patients information about how to raise formal complaints and we looked at a number of patient complaint responses to confirm this.

The service did not routinely have information leaflets available on the wards in languages spoken by the patients and local community, but staff confirmed these would be made available where a patient required them.

Managers made sure staff and patients could get help from interpreters or signers when needed. The hospital had a protocol in place, and agreements with a translator and interpretation service. The protocol contained information about links to service for patients who were deaf or hard of hearing.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. We looked at current menus to confirm that each mealtime, there was a vegetarian, vegan and a halal option. We were told that most meat that came on site was halal. The catering staff could respond to patients with specific dietary requirements and patients were supported to cook their own food if they wished.

Patients had access to spiritual, religious and cultural support. The hospital had a designated multi-faith room, which we visited, off the wards specifically for staff and patients to use for these purposes. Staff told us that a variety of spiritual and religious leaders visited the hospital regularly and, although these had stopped during the pandemic, they were starting again. These leaders would visit patients and speak with them on the wards as requested.

Listening to and learning from concerns and complaints

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

Good

Forensic inpatient or secure wards

Patients, relatives and carers knew how to complain or raise concerns. We looked at the latest patient and carer surveys to confirm this. We also looked at several patient complaint responses to show that staff understood the policy on complaints and knew how to handle them.

The service clearly displayed information about how to raise a concern in patient areas. We confirmed this when we toured the wards. Patients were also provided with an information booklet which included details about how to complain.

Managers investigated complaints and identified themes. We looked at the clinical governance meeting minutes for the three months prior to our inspection and saw some general themes around food, patient care, peer behaviour, staff behaviour, COVID-19.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We looked at several formal complaints to confirm that they were investigated, and staff responded in writing about whether their complaint had been upheld. The feedback also included details of how the patient could appeal if they were not satisfied with the outcome.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw examples of improvements that had been made as a result of informal and formal patient complaints. For example, the provider made changes to the quality and quantity of electronic cigarettes following patient complaints.

The service used compliments to learn, celebrate success and improve the quality of care. Staff regularly received compliments from patients, carers, and students on the wards and we looked at a sample of these over the course of 2021/22. Managers used team meetings to recognise staff for their efforts, and compliments were discussed by staff in management and governance meetings.

Are Forensic inpatient or secure wards well-led?

Good

Our rating of well-led went down. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

They focused on innovation and change to provide a better experience for patients. They had a vision for the direction of the service, to address identified issues and motivating and inspiring staff to achieve goals that would support enhancement. They understood the importance of good relationships, developing capacity and motivating others. There were strategies and support for addressing challenges staff may encounter.

Leaders had relevant and appropriate expertise. They understood the service and could explain how they were working to provide high quality care.

They encouraged and supported improvement and the delivery of excellent, person-centred care. Leadership was inclusive at all levels.

Leadership opportunities were available, including opportunities for staff below manager level.

Vision and strategy

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

The values, 'kindness, integrity, teamwork, excellence', encompassed good quality, safe care and underpinned the model provided. Staff understood the vision and values and knew how they applied to the work of their team.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff.

Staff understood how their work connected with the strategy. The care we saw being delivered and the conversations we had with staff demonstrated how the values were inherent in their practice. They were committed to providing care that focused on people's recovery, encouraging independence and confidence through positive risk taking in a safe place where patients could nurture and realise their goals.

Staff had the opportunity to contribute to discussions about the strategy for their services, especially where the service was changing.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The atmosphere at the hospital was calm and relaxed. Staff felt respected, supported and valued, and told us how the teams worked well together. They told us that patients helped set the culture, how they were the priority and that a lot of effort was put into including them. A recent review of hospital culture was positive.

Staff felt positive and proud about working for the provider and their team.

Staff felt able to raise concerns without fear of retribution. They found managers were approachable and willing to listen, and they told us they felt able to raise any concerns with them. They had access to all senior managers and had confidence that they could call any one of them at any time if they needed to. They had various ways to raise issues, such as ward meetings and supervision. Senior managers also held 'keeping in touch' sessions with all the teams, including catering and maintenance as well as ward teams. This helped create an open, relaxed atmosphere where staff could ask questions and receive reassurances.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.

Managers dealt with poor staff performance when needed. They investigated any concerns raised confidentially. Performance that was not in line with the vision and values was recognised and addressed. They took steps to put things right and shared lessons learned. Staff told us there was low tolerance of people not being kind.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.

Staff had access to support for their own physical and emotional needs through an occupational health service, plus psychology support on site if needed, such as if staff experienced challenging incidents during their work. The service also provided a range of staff wellbeing initiatives, such as massage, various therapies and an advice and counselling helpline.

The provider recognised staff success in the service. There was a monthly recognition draw, where staff could nominate colleagues for the opportunity to win prizes.

There was strong team-working and support. The teams focused on improving care and people's experiences. Managers encouraged positive relationships between staff so that they felt valued and supported. There were events to support staff and promote their wellbeing.

Staff took part in satisfaction surveys, and staff leaving were offered exit interviews. The provider used these to identify areas for improvement.

Governance

Our findings from the other key questions demonstrated that governance processes mainly operated effectively at team level and that performance and risk were managed well.

The risk register was reviewed at clinical governance meetings, which took place every quarter. We saw that it had been reviewed at the last meeting in June 2022. However, it was difficult to identify when each risk had been added and when action had been taken to address the risk.

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information, such as learning from incidents, was shared and discussed. The provider had policies to guide staff in the day-to-day operation of the service.

Clear governance systems promoted good oversight. Governance was fundamental to service development and was informed by meetings of patients, carers and staff across the service, feedback from surveys, consistent audit and monitoring, following a 'ward to board' model. Patients were involved in governance at all levels. Information gathered was used to prioritise improvements. Managers made necessary changes and ensured learning was disseminated.

Governance and performance processes reflected best practice. They were effective and strong, they identified and addressed issues and were used to make improvements.

Senior staff, managers and allied health professionals attended a handover meeting every morning. They received a patient handover from each ward, and they discussed issues across the hospital such as ward issues, incidents, complaints, safeguarding, risks, ward to board issues and MDT issues. They also reviewed quality monitoring information from the electronic dashboards.

Good

Forensic inpatient or secure wards

Managers had effective systems to ensure the forensic wards were well staffed and that patients were safe and treated kindly. Patients were involved in governance meetings and managers made necessary changes and ensured learning was disseminated.

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

Staff undertook or participated in regular clinical audit to ensure quality, such as care plans and risk management plans, which were monitored via the electronic dashboards. There was a medicines management group that carried out audits. The audits were sufficient to provide assurance and staff acted on these results when needed. Audit findings were dealt with in a timely manner.

Staff understood the arrangements for working with other teams, both within the service and external, to meet the needs of patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers recognised the issues the service faced. They had oversight of governance issues via electronic dashboards that held records relating to, for example, clinical notes, multidisciplinary team and service user meetings, learning and development, physical health, safe staffing and risk. They used the dashboards routinely to monitor performance targets.

The provider maintained a risk register, dated June 2022, which was informed by sources such as information and data collated from monitoring and audits. Staff understood how they could escalate concerns.

Potential future risks were included, such as staffing. Other risks identified included information technology failure, possible breakdown of communication with key stakeholders, and emergencies such as outbreaks of illness. There were identified controls and action was taken to address and mitigate risks.

Managers discussed and monitored risk daily at morning handover meetings, and risk was regularly discussed at clinical governance meetings.

Leaders monitored service performance. They identified problems and addressed them quickly. If something went wrong, they considered what had gone wrong and what was needed to correct it.

Audit processes were constructive and provided clear indications so that issues were identified and addressed.

Staff at all levels were involved in service developments so that they understood the effect on quality and service delivery.

Information management

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

Good

Forensic inpatient or secure wards

The service used systems to collect data from wards, which were not onerous for frontline staff. Leaders had access to information that supported them to adapt and develop performance. They used the information gathered to generate improvement.

Staff had access to the equipment and information technology needed to do their work. They used technology to update records, which meant current information was always accessible.

The service managed information via electronic dashboards, which held a range of information, such as care plans, risk assessments, physical health checks and daily activity, and were updated regularly. Using the dashboards, the information could be evaluated in total across the hospital and any issues noted.

Staff were committed to sharing information so that choices and decisions were supported.

Information governance systems included confidentiality of patients' records.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

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

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used.

There was a clear commitment to patient and carer involvement that was apparent at all levels.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. A review of ward culture sought patients' views and the results were positive.

Staff and patients met every month to discuss ward issues. Patients suggested and were involved in a variety of issues, such as review of menus.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes in the service. Patients were involved in how the service operated, through various meetings beginning at ward level and feeding into governance.

Carers were encouraged to be involved, via the carers' forum and participation in meetings that fed into governance. There was a carers charter that recognised their expertise and set out how they could be involved and what they could expect from the service.

Patients and staff could meet with members of the provider's management team to give feedback.

Good

Forensic inpatient or secure wards

Staff were committed to patients' recovery. They encouraged and supported patients to become involved in the community and to develop their skills for independent living. The service had developed relationships with the local community that supported patients to progress their skills and education. There were also links with organisations, such as the police, to build recognition of patients' needs.

There were good relationships with commissioners and with other services in the region. The provider was involved in local partnerships that considered, for example, patient safety by looking at the resilience of services, and the provision of a range of appropriate interventions to enable effective pathways out of services.

Learning, continuous improvement and innovation

There was a clear commitment to development and improvement. There was a shared ethos of ongoing change and progression. Leaders and staff were driven to bring about improvements. Patient engagement and participation was ongoing and strongly supported by staff. The provider used information and learning from monitoring, audit and reviews to make improvements. Managers prioritised service improvements.

For example, the provider had a quality improvement initiative to help patients live healthier lives and improve their physical wellbeing. There was a comprehensive healthy living programme, led by a physical health and wellbeing coach, that educated patients about fitness, healthy eating and nutrition and helped them improve physical fitness. Staff regularly monitored patients' body mass index, weight and cholesterol levels. Managers monitored when overall levels were rising and discussed strategies to reduce this.

Staff were encouraged to consider possibilities for improvement and development of the service. They engaged in appropriate national audits, and they were encouraged to develop their skills through training and experience, appraisal and career development discussions. The service regularly contributed to the prescribing observatory for mental health, a Royal College of Psychiatrists initiative to improve prescribing practice nationally.

Staff had adapted their skills and knowledge to care for a patient whose presentation was outside their usual experience. They had learned about the issues involved so that a personalised, enhanced package of care could be provided.

The service participated in relevant accreditation schemes. High performance was recognised by credible external bodies. The medium and low secure services were an established member accredited by the Royal College of Psychiatrists quality network for forensic mental health services. The psychiatric intensive care service participated in the quality network for psychiatric intensive care units. The service had been assessed for accreditation and was awaiting the outcome.

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	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider must ensure that all restrictions, such as opening mail in front of staff, and the practice of selecting patients to be searched in the rehabilitation service, are individually risk assessed and compliant with the Mental Health Act Code of Practice (Regulation 13 (1) (2) (4) (b).