Cheswold Park Hospital

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

Our rating of this service improved. We rated it as good because:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- 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 these staff received training, supervision and appraisal. 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However;

- Not all staff were trained in the use of physical intervention.
- Staff did not keep records of seclusion in line with the Code of Practice.
- The mobile phone and mail management policy was not in line with the Code of Practice.
- Not all patients with long term conditions received regular review by an appropriate clinician.
- Staff did not always record the reason for the use of prone restraint in incident records.
- Staff did not always record when patients and staff received a de-brief following an incident.
- The hospital policy for patients with transgender needs was not written in plain English and did not reference any national sources of information.
- Information about transgender support groups was not available on the wards.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Good 	

Summary of findings

Contents

Good

Location name here

Services we looked at
Forensic inpatient or secure wards

Summary of this inspection

Background to Cheswold Park Hospital

Cheswold Park Hospital is a purpose-built hospital in Doncaster. Riverside Healthcare Limited is the provider. The hospital provides low and medium secure accommodation for men over 18, with mental disorders and learning disabilities with an offending background, who require assessment, treatment and rehabilitation within a secure environment. The hospital has the capacity to provide care and treatment for up to 96 patients detained under the Mental Health Act.

The hospital is registered with the Care Quality Commission to provide the following regulated activities:

• Diagnostic and screening procedures

• Medical treatment of persons detained under the Mental Health Act 1983

• Treatment for disease, disorder or injury.

The hospital does not currently have a registered manager; the previous registered manager left in April 2019 but a member of the senior management team had put an application forward to become the registered manager. This was in the process of being assessed when we carried out the inspection. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. The hospital had a controlled drugs accountable officer on site. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

In May 2019 the hospital completed work which supported the transforming care programme. By merging Gill, Hebble and Wilton wards; the hospital reduced its medium secure bed base from 29 to 15 beds and Haven ward was created.

The hospital has two medium secure wards and five low secure wards.

The wards are:

• Aire – 12 bed low secure mental illness acute admission and assessment

• Brook -16 bed medium secure mental illness/ personality disorder

• Calder –16 bed low secure personality disorder rehabilitation

• Don – 12 bed low secure personality disorder assessment

• Esk – 12 bed low secure mental illness

• Foss – 12 bed low secure mental illness

• Haven – 15 bed medium secure learning disability and autistic spectrum condition admission and assessment

In addition, using one of the closed wards, the hospital has developed The Grange, a suite to support individual patients.

The CQC completed five Mental Health Act monitoring visits to the hospital between March 2018 and November 2018. Issues identified included records relating to seclusion, capacity to consent to treatment, treatment authority certificates and recording of carer input into care plans. During this inspection we reviewed a sample of these actions and were assured the service had addressed a number of the issues identified and were progressing with others.

We last inspected the hospital in February 2018. We rated this service as 'requires improvement' overall with ratings of 'good' in the caring and responsive key questions, and requires improvement in safe, effective and well-led. The hospital was in breach of the following regulations:

- Regulation 9 Health and Social Care Act 2008 Person centred care
- Regulation 11 Health and Social care Act 2008 Need for consent
- Regulation 12 Health and Social Care Act 2008 Safe care and treatment
- Regulation 13 Health and Social Care Act 2008 Safeguarding service users from abuse and improper treatment
- Regulation 18 Health and social Care Act 2008 Staffing

Summary of this inspection

We also suggested some actions which the provider could take to improve the service; including risk assessment of equipment, availability of ligature risk assessments on wards and protection of patients' privacy and dignity on wards.

Our inspection team

The team that inspected the service comprised of one team leader, two CQC inspectors, one assistant inspector, four specialist advisors; (a learning disability nurse, a dual qualified nurse, a senior nurse and occupational therapist), a Mental Health Act reviewer, a medicines inspector and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 33 patients who were using the service; including nine patients in two focus groups;
- spoke with four family members
- spoke with the chief executive, chief nurse and medical director;
- spoke with seven ward managers;
- spoke with 35 other staff members; including doctors, nurses, support workers, occupational therapist, psychologists, physiotherapist, nutritionist, speech and language therapist and social workers;
- received feedback about the service from one commissioner;
- received feedback from the independent advocacy service;
- attended and observed one morning business meeting and one multi-disciplinary meeting;
- collected feedback from five patients using comment cards;
- looked at 20 care and treatment records of patients;
- carried out a specific check of the medication management on three wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

Patients told us staff were caring, respectful and helpful. Except for one, all patients felt safe. Patients we spoke with told us they had good relationships with regular members of staff, felt supported and listened to. Two patients on Haven ward told us there was not always enough staff to meet their needs.

Patients liked to take part in different activities within the hospital and local community. Patients felt they had access to a good variety of things to do, although two patients felt that therapies were limited. Most patients enjoyed the food and felt the hospital environment was clean. Patients appreciated the opportunity to be involved in hospital wide meetings.

Feedback from families and carers we spoke with was mixed regarding their level of engagement with the service. Families and carers told us communication could be improved and staff could provide more regular updates. However, when families and carers contacted the hospital, they received a positive response. Families and carers had the opportunity to attend the hospitals family forum, to share ideas and keep up to date with the work of the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- Although we found the service largely performed well, it did not meet the legal requirements relating to staff training and maintaining accurate and complete records for those patients in seclusion.
- Not all staff were trained in the use of physical intervention.
- Staff did not keep records of seclusion in line with the Code of Practice. Not all records included documentation of 15 minute observations, timely medical review, multi-disciplinary reviews including professionals other than the nurse and doctor and a care plans that identified what was required to end a period of seclusion.
- The mobile phone and mail management policy was not in line with the Mental Health Act Code of Practice.
- Not all patients with long term conditions received regular review by an appropriate clinician.
- Staff did not always record the reason for the use of prone restraint in incident records.
- Staff did not always record when patients and staff received a de-brief following an incident.

However;

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement 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.
- 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.

Summary of this inspection

- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- 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.
- The wards had a good track record on safety. 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.

Are services effective?

Good

Our rating of this service improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- 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 a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. 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 and engaged with them early on in the patient's admission to plan discharge.

Summary of this inspection

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

Are services caring?

Good

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

- 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 involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However;

- The hospital policy for patients with transgender needs was not written in plain English and did not reference any national sources of information.
- Information about transgender support groups was not available on the wards.

Are services responsive?

Good

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

- Staff planned and managed discharge well. They liaised with services that would provide aftercare. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service 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 a good quality and patients could make hot drinks and snacks at any time.
- Staff helped patients with communication, advocacy, cultural and spiritual support.

Summary of this inspection

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

  However;
- The service did not meet the needs of all patients who used the service – including those with a protected characteristic.

Are services well-led?

Good

Our rating of this service improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However;

- Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level in relation to the application of the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Detailed findings from this inspection

Mental Health Act responsibilities

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

The CQC completed five Mental Health Act monitoring visits to the hospital between March and November 2018. Issues identified included records relating to seclusion, capacity to consent to treatment, treatment authority certificates and recording of carer input into care plans. During this inspection we reviewed a sample of these actions and were assured the service had addressed a number of the issues identified and were progressing with others. However, we identified that the hospital policy for mobile phones and mail management was not in line with the Mental Health Act Code of Practice.

We reviewed consent to treatment documentation and all patients were prescribed medicines in accordance with the provisions of the Mental Health Act. Medicines were reviewed regularly and second opinion approved doctors sought when required.

All staff were trained in the Mental Health Act and its Code of practice. The hospital had a Mental Health Act administrator to provide staff with additional knowledge and guidance.

Patients had their rights under the Mental Health Act explained to them on admission and regularly thereafter. Staff had access to copies of easy read versions of patient rights.

Staff completed regular audits to ensure that the Mental Health Act was being applied correctly. Outcomes of these audits were shared with staff during meetings and monitored via governance arrangements.

All patients had access to an Independent Mental Health Advocate. The advocates visited the hospital regularly and supported patients on a range of issues. The hospital displayed information on how to contact the advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff were trained in the Mental Capacity Act and staff had a good understanding of its application and principles. Care records included capacity assessments in relation to specific decisions, such as care plans, consent to treatment and finances.

Mental capacity assessments were reviewed regularly and monitored through Mental Capacity Act audits and the use of a database.

There were no Deprivation of Liberty Safeguards applications in place at the time of this inspection. The provider had a policy to support and guide staff on the Deprivation of Liberty Safeguards.

Overview of ratings

Our ratings for this location are:

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

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

Safe and clean environment

Safety of the ward layout

The hospital was safe, clean and well maintained. Staff completed regular risk assessments of the care environment. The service had up to date health and safety and fire risk assessments. Staff completed weekly fire alarm tests, monthly fire extinguisher and emergency lighting testing and an external contractor was responsible for maintaining alarm systems and completing annual fire risk assessments.

Staff completed the annual ligature risk assessment of the hospital in February 2019. Ligature risks were rated as low, medium or high, there were no high risk ligatures identified within the hospital. Staff mitigated low and medium ligature risk through patient observation and regular reviews of patient risk assessments. All ligature risk assessments were reviewed and updated following an incident in May 2019 and the hospital has completed the majority of the required work to mitigate the identified risk. All bedroom and bathroom doors were anti-barricade, they prevented barring, holding and blocking by patients. For those patients at an increased risk of deliberate self harm or suicide, the hospital installed pressure pads on en-suite bathroom doors of two bedrooms on each of the admission wards Aire, Brook and Haven. The pads would activate an alarm should an increased weight be detected. Following evaluation of this initiative, the hospital plans to rollout solutions to adapt existing doors or install suitable replacements.

The layout of individual wards allowed for clear lines of sight for staff to observe patients. Staff mitigated patient risk through individual patient risk assessment and management plans which identified appropriate levels of observation. Staff completed a competency based assessment for carrying out observations of patients, between 81% and 96% of staff were compliant with this training. Bedroom corridors and communal areas, such as lounges and activity rooms were monitored regularly by allocated staff on each ward and the use of CCTV strengthened the safety of both patients and staff.

Staff were issued with a personal alarm whilst on duty. These were tested and issued to staff before the commencement of duty. Patients had easy access to nurse call alarms in the event of an emergency.

Hospital practice regarding the balance between care and security reflected NHS guidance ‘See, Think, Act.’ Relational, procedural and physical security were delivered sensitively by staff. Relational security formed part of staff induction; including an annual update, and the hospital recently developed the Health, Safety and Security Committee to strengthen its approach.

Maintenance, cleanliness and infection control

The hospital was visually clean, had good furnishings and was well maintained. The hospital had a daily and weekly cleaning schedule in place to ensure the cleanliness of the hospital. Cleaning records demonstrated that the hospital was cleaned regularly. The hospital has trained all housekeeping staff in line with a nationally accredited

programme and have been successful in their application to be an accredited training hub. The maintenance team worked closely with staff to fulfil the annual schedule of planned works and provide a responsive service for emergency work and repairs.

Staff adhered to infection control principles, including handwashing, and hand sanitizer was available for people to use. Personal protective equipment was available and was stored securely.

Seclusion

The hospital had four seclusion rooms. Each seclusion room offered clear observation of patients, had an intercom that allowed for two-way communication and patients were able to see a clock which showed the correct time. Patients in seclusion had access to natural light and blinds were in place which could be operated by staff to minimise light. However, one blind did not operate to allow in natural light in Jarrow seclusion, Lakeside and Keepmoat had skylights, this did not afford patients a view outside. Anti-ligature bedding was provided to patients in seclusion rooms.

During this inspection we reviewed a care record for one patient who was receiving care in long term segregation. The environment was appropriate for this use, with plenty of space for the patient. The patient was supported to leave the ward when he was able and to socialise with other patients. The record clearly showed the clinical picture prior to the decision to use long-term segregation and the decision-making process. The management of the segregation was in order, with a recent external review. Staff were considering any use of seclusion as a continuation of the long-term segregation in respect of the review timetable. During periods of seclusion the timetable for more frequent seclusion reviews was being used.

Clinic room and equipment

The hospital had a number of clinic rooms and a physical healthcare suite, these were clean and tidy and had the necessary equipment to carry out physical examinations. There were adequate medicines and equipment for use in a medical emergency, systems were in place to regularly check they were fit for use. A risk assessment had been completed to demonstrate the rationale for the decision to keep emergency grab bags on only two of the wards. At the previous inspection we told the hospital they must ensure that response times to emergencies involving resuscitation comply with national guidance. At this inspection we found that the hospital had updated its medical emergency and resuscitation policy to include national guidance. In addition, staff had successfully completed a series of drills to test staff in an emergency; including resuscitation.

Cleaning of equipment and checking the clinical fridges was routinely carried out and records demonstrated this. However, on Haven and Brook wards, the temperature of the medicines refrigerator had been recorded as one degree Celsius on several days during the month of June, which is lower than the recommended range for storing medicines. No action had been recorded to demonstrate this had been followed up. On Esk ward, staff recorded the current temperature of the medicines refrigerator rather than the maximum and minimum temperature as per the hospital policy.

Safe staffing

Staffing levels were adequate to meet the needs of patients. At the time of inspection, there were no vacancies for qualified nurses or healthcare support workers. Carers and patients did not raise any concerns about the availability of staff to speak with; patients could access one to one time with named nurses.

The service used a staffing calculator to determine the required number of staff for the hospital. The service had 58.3 whole time equivalent staff nurses and 169.3 whole time equivalent healthcare support workers. The hospital had above their establishment for qualified nurses and support workers. There were 10.4 additional qualified nurses and 13.22 additional support workers across the hospital. Staff worked day or night shifts, from 07:30 until 20.00 and 19:30 until 08.00. The service staffed each ward during the day with a minimum of two qualified nurses, except for Haven, where three qualified nurses worked each day shift. During the day shift, between three and six healthcare support workers were present on each ward, except for Haven, where ten healthcare support workers were required. At night, each ward had a minimum of one qualified nurse and between two and six healthcare support workers, except for Haven, who had ten healthcare support workers at night. Ward managers told us they could adjust the staffing levels to meet the changing needs of patients. In addition, the ward managers and deputy ward managers supported staff during core working hours.

Good

Forensic inpatient or secure wards

Ward managers reviewed staffing numbers regularly to ensure staffing was adequate and to ensure patients could be supported safely. This included discussion of the balance between male and female staffing compliments. Oversight of the daily staffing compliment was monitored through the hospital morning meeting and managed through the daily duty manager. When shortfalls in staffing were identified, staff worked flexibly across the wards. Of the 28 ward-based staff we spoke with, eight staff members told us staff were regularly moved to work in other areas, predominantly to Haven ward. Of the nine patients we spoke with on Haven ward, two patients told us there was not always enough staff and one patient told us they preferred regular members of staff to agency staff. Haven ward opened on 13 May 2019, alongside two regular qualified nurses. qualified agency staff provided cover for eight shifts and healthcare support workers for 18 shifts, up until 23 June 2019.

There were adequate numbers of staff to carry out physical interventions safely, including observations and restraint. Although the number of staff trained in physical interventions was low, staff allocated to respond to incidents across the wards were up to date with training. However, one staff member told us there was potential for burnout of staff responding to incidents due to the frequency of being allocated to a response role.

Staff shortages occasionally resulted in staff cancelling or rearranging escorted leave. Between 01 March 2019 and 31 May 2019, Section 17 leave had been cancelled or changed on two occasions, once each on Brook and Foss wards. Staff and patients on Aire ward told us section 17 leave was cancelled for one day during June 2019. We requested information from the hospital regarding this, we were assured this was an isolated incident and alternative arrangements were made for patients. Of the 24 patients we spoke with during this inspection, three patients told us that Section 17 leave had been cancelled due to staffing, the majority of patients did not raise concerns regarding access to escorted leave or activities.

The staff turnover rate for the hospital was high. Between 01 June 2018 and 31 May 2019, the staff turnover rate was 46%, down from 53% in the previous 12 months. We discussed this with the recruitment and human resources manager, 76 staff had left the service; including 58 healthcare support workers and 18 qualified nurses. The majority of staff had resigned from their posts and 15 staff were dismissed during their probationary period. We discussed our concerns with the recruitment and human resources manager and were assured that work was ongoing in recruiting staff with the right skills into this specialist area of healthcare. This included focussed recruitment initiatives for medium secure forensic services. Alongside this, the hospitals new Quality Strategy 2019-2021 demonstrated how the service planned to support and develop staff in their roles.

Between 01 December 2018 and 31 March 2019 bank and agency use fluctuated, with an average of 51 shifts per week being covered by bank or agency staff across all seven wards. Foss had the fewest shifts covered by agency staff (4), Brook and Haven had the highest use, with 196 and 258 shifts respectively. At the time of this inspection, three agency staff were blocked booked to work shifts and were familiar with the hospital and patients. Bank and agency staff received the same induction as regular staff prior to working in the clinical areas.

The sickness rate for the service was 3.8% between 01 April 2018 and 31 March 2019. The sickness rate reported during this inspection was higher than the 3% reported at the last inspection. We discussed this with the ward managers and they told us although absence rates had increased slightly, long term sickness and ad hoc absence remained a challenge.

Medical Staff

There was adequate medical cover for the hospital day and night. The hospital had five consultant psychiatrists to work with patients and three junior doctors. The hospital used an on-call rota, in the event of a psychiatric emergency doctors could respond within approximately 15 minutes and provision was made within the hospital for doctors to stay overnight if required. For physical health emergencies, staff contacted the local emergency department or dialled 999 for an ambulance.

Mandatory Training

Staff had completed the required mandatory training. The compliance for mandatory training courses at 31 March 2019 was 94%, all courses achieved above the providers target of 90%. Compliance in key training such as safeguarding, immediate life support and Mental Capacity Act ranged from 83% to 99%. The training compliance reported during this inspection was higher than the 93% reported at the last inspection.

However, sufficient staff did not complete training for managing violence and aggression. The hospital reported that 56% of staff were trained. In March 2019 the hospital switched to an accredited training programme for managing violence and aggression and were in the process of rolling this out across the staff group. As of 24 June 2019, 48% of staffed were trained in managing violence and aggression. The hospital identified staff working on Haven as a priority for training, as this ward had the highest number of recorded incidents, 80% of staff on Haven had received training. Esk ward had the fewest members of staff trained (21%). The hospital had an implementation and steering group to oversee the roll out of the new training programme.

Assessing and managing risk to patients and staff

Assessment of patient risk

During this inspection we reviewed 20 care records in detail. The service used two nationally recognised risk assessment tools; the Historical Clinical Risk Management 20 and the Functional Analysis of Care Environment . The risk assessments covered a range of issues such as; violence to others, harm to self, behaviour and patient specific risks, such as sexualised behaviour.

Risk assessments were up to date and had been reviewed regularly. Staff recorded the risk history of all patients in detail and current risks were clearly documented. Staff consistently updated risk assessments following incidents and included reference numbers of incident reports submitted. Some patients were responsible for their own medication and we noted that appropriate risk assessments were in place for this to be safely managed and monitored.

Following the last inspection, we told the provider they must ensure staff carried out risk assessments for patients with mobility needs. We reviewed one care record specifically relating to the assessment of mobility needs. Staff had completed the required risk assessments for mobility, risk of falls and use of equipment.

Management of patient risk

Staff were aware of and dealt with specific risk issues. Due to the range of complexity and challenging needs of the patient group, staff completed specific risk assessments; including physical health needs and physical intervention. Where required, patients had health action plans, staff updated these and reviewed them regularly. These risk assessments identified additional needs and enabled staff to manage them appropriately.

Staff identified and responded to the changing needs of patients. The provider had a therapeutic observation and engagement policy to support and protect patients and staff. We observed staff regularly and consistently undertake observations of patients, as required by the providers policy. Due to the varied needs of the patient group, patients were supported by staff on a range of different observation levels; from continuous observation to less frequent checks. Staff recorded their observations in patient care records. Staff discussed patient observation levels regularly, staff told us they discussed this during daily handovers and weekly multi-disciplinary team meetings. We observed the clinical team and multi-disciplinary team discussing observation levels during a patient's weekly ward round and the daily hospital morning business meeting.

Staff did not routinely search patients or their bedrooms. The provider had a search policy to guide staff, this was subject to full review in June 2019 to ensure compliance with the Mental Health Act Code of Practice and national guidance. Section 17 leave authorisation forms indicated searching requirements for each patient following leave from the hospital. Staff risk assessed patients individually regarding the need to be searched and recorded the outcome of this on leave authorisation forms. The hospital also used a 'Wheel Decide' randomiser for those patients that did not require searching. This is an electronic programme based searching on a 1:4 probability ratio of search or don't search for patients returning from leave.

The hospital had a restrictive practice register and all wards had individual restrictive practice logs. In the care records reviewed, we saw reducing restrictive practice assessment tools. These detailed specific individual patient restrictions.

Staff and patient representatives attended a monthly meeting to discuss reducing restrictive practice; including blanket restrictions, physical intervention and seclusion. Meeting minutes reviewed highlighted a positive approach to reducing restrictive practice within the hospital. There was acknowledgment that reducing restrictive practice

remained a priority and staff required further training regarding blanket restrictions. The hospital also reviewed practice from external providers in the Yorkshire and Humber region to inform its own approach.

Current restrictions focussed on specific items, these included e-cigarettes, mobile phones, mail and searching of patients. Staff told us access to; and management of e-cigarettes was a current challenge across all wards. To promote a smoke free environment, the hospital allowed the use of e-cigarettes within the communal garden of each ward. Each ward had access to the communal gardens based on a rota; this was to promote patient engagement in therapeutic activities and reduce the potential risk of adjoining wards being out in the gardens together, therefore preventing passing of contraband and reducing the risk of verbal or physical altercations. Each ward rota gave patients regular opportunities to use their e-cigarettes. The majority of patients we spoke with did not raise concerns about accessing their e-cigarettes, two patients told us they wanted to be able to use their e-cigarettes more than every hour. During this inspection, staff held a reducing restrictive practice meeting to discuss potential ways the service could deliver this element of care differently. The hospital has agreed to review this process, with a view to supporting patients on adjoining wards to access outside space at the same time. Smoking cessation information and support was available to patients. Staff supported patients that did not use e-cigarettes to access outside space when they requested.

At the previous inspection in February 2018 we identified blanket restrictions regarding access to mobile telephones and mail management. During this inspection we identified that the hospital had made progress with this blanket restriction, however the provider policy 'Patient Access to Phones and Mail Management' required a full review to accurately reflect the Mental Health Act Code of Practice; this is scheduled for August 2019.

At the time of this inspection there were no patients informally admitted to the hospital.

Use of restrictive interventions

The use of restrictive interventions has fluctuated since the last inspection in February 2018, more recently staff have used fewer restrictive interventions. Prior to this inspection the provider submitted data regarding the use of restrictive interventions between 01 September 2018 and 28 February 2019. Staff used seclusion on 201 occasions, these were highest in Gill (Now Haven) and Brook wards. This was a slight increase on that reported at the previous inspection (182) in February 2018. The long-term segregation of patients was rare, between 01 September 2018 and 28 February 2019 the hospital reported only one episode of long-term segregation.

Staff used restraint on 449 occasions, involving 32 different patients. Gill ward (Now Haven) used restraint on 263 occasions. The use of restraint had increased from 250 reported at the previous inspection. The provider reported 19 incidents of restraint that were in the prone position. We reviewed 11 records relating to the use of prone restraint. Four records indicated prone restraint was used to ensure staff could safely exit seclusion and seven records did not evidence why prone restraint was used. We reviewed recent incidents, including restraint and seclusion between 01 January 2019 and 24 June 2019. During this time staff used restrictive interventions less frequently, 309 incidents were recorded; of these, four were in prone and appropriately recorded the reason for this.

The hospital had a reducing restrictive practice strategy and audit in place, this ensured restrictive practice; including any blanket restrictions were monitored and regularly reviewed.

Staff we spoke with understood the definition of seclusion and that restraint should be used only after other de-escalation attempts had been made. Staff were able to describe methods they would use to manage incidents prior to attempting restraint. Staff told us they would only use restraint if it was necessary for the safety of patients and staff. During this inspection we observed staff on Haven ward de-escalating a patient who was agitated. Staff were calm, reassuring and encouraged the patient to use their coping strategies. The incident was diffused quickly by competent and respectful staff.

The hospital had four seclusion rooms; Jarrow, Keepmoat, Lakeside and the Isle Suite. During this inspection they were not in use by patients. Staff used seclusion appropriately, however, staff did not always keep records of seclusion in line with the Code of Practice and the hospital policy.

The hospital had a seclusion pack, this contained all the required documentation for commencing, monitoring and ending seclusion. We reviewed eight seclusion records in

detail from five different wards. We identified a series of concerns regarding seclusion documentation; including omissions of 15-minute observations, late medical review, multi-disciplinary reviews did not include professionals other than the nurse and doctor and care plans did not always identify what was required to end a period of seclusion. The hospital seclusion audit tool failed to pick up the late medical review, the late independent multi-disciplinary review and lack of risk assessment for one seclusion episode.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

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

The hospital required all staff to complete safeguarding training for adults and children and 97% of staff had completed this training. Staff also completed 'Prevent' training, a training module to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. The hospital submitted 104 safeguarding notifications between 1 June 2018 and 31 May 2019 to the CQC.

Staff had easy access to safeguarding information through the hospitals intranet and on display within the hospital. The hospital had a safeguarding policy to support staff in identifying, understanding and reporting abuse. The hospital had an identified safeguarding lead and staff were aware of who this was and how to contact them. The hospital had an established Safeguarding, Whistleblowing and Complaints Committee, they met regularly to discuss safeguarding within the hospital, review data; including themes and trends.

Staff we spoke with identified potential safeguarding concerns relevant to the patient group and were confident about how they would respond to such a concern. Staff within the hospital based social work team received additional training from the local authority to enable them to complete initial safeguarding investigations. The wider staff group contributed to safeguarding investigations involving the local authority and the police. The local authority visited the hospital regularly to provide ongoing support and complete safeguarding investigations. Staff discussed safeguarding issues regularly as part of the morning business meeting and during staff meetings.

In September 2018 the local authority commissioned an adult safeguarding review of the hospital following a serious incident, the review sought to gain a broad view of issues within the hospital. Following the publication of the report in February 2019, the hospital engaged with commissioners, the CQC and the local authority to implement recommendations.

Staff followed safe procedures for children visiting the hospital. A dedicated visits room off the main clinical areas was available for visits and the provider had a policy to support staff regarding children visiting the hospital.

Staff access to essential information

The service had a paper-based system to record patient information. All records were stored securely in locked cupboards on each ward. All staff, including bank and regular agency staff had easy access to the patient care record. Care records were organised, although remained extensive, with a wide range of care plans, assessments and daily notes.

The hospital had commissioned a new electronic patient care record and staff acknowledged that progress had been slow due to changes in the requirements of the new electronic record. The hospital appointed an information technology manager to co-ordinate the safe implementation of the electronic care record and progress was monitored through the recently introduced 'Data Oversight Group.' Staff on Esk ward were piloting the new electronic care record and were optimistic regarding its use. Staff across the hospital, particularly members of the multi-disciplinary team told us they were positive about the introduction of the electronic care record.

Medicines management

The systems in place for managing medicines mostly minimised risks and kept patients safe.

Good

Forensic inpatient or secure wards

We reviewed eight medicines charts and patient records in detail and found staff kept accurate records of the treatment patients received. Prescriptions for medicines to be given as or when required contained sufficient information to enable nurses to administer them safely.

We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. We saw evidence that treatment was regularly reviewed, for example Section 61 review of treatment certificates.

We checked physical health monitoring for patients who were prescribed antipsychotic medicines. Blood tests, ECGs and physical observations were carried out in accordance with national guidance and best practice recommendations. However, records were not always readily available in the care plan file for each patient. One patient was prescribed a medicine which required regular monitoring of blood levels to ensure the treatment remained safe and effective. We saw this monitoring had been completed at the appropriate intervals, and the results were recorded in the patient's file.

Two patients were prescribed high dose antipsychotic treatment, which carries a greater risk of adverse effects. In both cases, treatment had been regularly reviewed by the responsible clinician. In addition, appropriate monitoring had been carried out to ensure the treatment remained safe and beneficial.

The service was aware of and worked towards achieving the outcomes of the national project 'stopping over medication of people with a learning disability, autism or both with psychotropic medicines.' (STOMP)

Track record on safety

Between 01 March 2018 and 28 February 2019 there were 33 serious incidents, which required investigation. This was more than the 28 reported at our last comprehensive inspection in February 2018. The hospital had a serious incident policy, and this had been reviewed in May 2019.

We reviewed five serious incidents and found that the hospital investigated the incidents in line with their policy. Each serious investigation report had an action plan, detailing individuals responsible for actions, with clear timeframes. The service had strengthened the monitoring of these actions through regular individual ward reviews, involving senior managers and ward managers. We reviewed information for individual ward reviews for Don and Brook wards, action plans were clear and had been updated.

Reporting incidents and learning from when things go wrong

All staff recognised incidents and reported them appropriately. Staff received feedback about incidents and learning from incidents was evident.

The service had an electronic recording system for reporting all incidents. The hospital incident policy was updated in June 2019 and provided staff with guidance on what type of incidents to report; including restraint, seclusion, verbal and physical violence. The reporting of incidents was monitored daily via the morning business meeting, this ensured an accurate picture of incidents was established and reporting was timely.

Nursing staff across the hospital received additional training regarding the completion of incident forms. Managers told us the reporting of incidents had increased and the quality of the reports had improved.

We reviewed incident data, between 01 December 2018 and 31 May 2019, staff reported 1297 incidents of violence and aggression. There was an even spread between incidents involving physical, verbal and threats of violence. During this time Haven ward recorded 63% of all physical aggression incidents, 53% of threats of violence and 38% of verbal aggression. Foss ward reported the least number of incidents, four (1%) for threats of violence. Senior managers told us Haven ward received enhanced monitoring regarding incidents, due to frequency and the current patient mix. Following the merger of Gill and Hebble wards in response to the transforming care programme; the patient mix on Haven ward remained challenging.

Staff received feedback about incidents through a range of sources; including staff meetings, supervision, daily handovers and email. Investigations external to the service, such as those undertaken by the local authority, police or independent investigations, were shared with staff.

Learning from incidents within the hospital was evident and changes to practice implemented. For example, following the absconsion of a patient whilst on Section 17 leave, the hospital worked with the police and CCTV

operators within Doncaster. This enabled the hospital to have direct radio communication with these services should this type of incident occur. The hospital produced a monthly lesson learnt bulletin for staff covering all wards. This identified findings from investigations, actions and lessons learnt. Alongside this, staff discussed learning from incidents; including serious incidents, in ward based and hospital wide governance meetings.

Patients and staff did not always receive a de-brief following an incident. Most staff told us they received a de-brief following an incident and some patients. However, incident forms submitted in May 2019 (309), recorded 78 de-briefs had taken place. Managers were aware of this issue and agreed to review and launch a focussed piece of work regarding de-briefs by the end of August 2019. Psychology staff provided de-brief and support following serious incidents.

The duty of candour is the requirement that staff are open and honest to patients/or carers when things go wrong with care and treatment. We saw some examples of good practice whereby staff had offered apologies to patients when things had gone wrong, this was in line with the providers policy.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the mental and physical health needs of patients on admission to the hospital. Care plans, which met patient needs identified during assessment, were reviewed regularly and were recovery orientated.

We reviewed in detail 20 care and treatment records. Staff completed a comprehensive mental health assessment for all patients upon admission, incorporating pre-admission information and taking into consideration the patients physical, psychological and social needs. Staff assessed the physical health needs of patients in a timely manner after admission.

Staff developed individual care plans that met the needs of patients identified during assessment. Care plans within the records reviewed were detailed, drawing together patient risk, positive behavioural support and evidenced a multi-disciplinary approach to care. At the previous inspection in February 2018 we told the provider they should ensure staff document patient pain management plans in the appropriate place in patient care records. During this inspection we reviewed one care record in relation to pain management. The patient had an appropriate care plan in place regarding pain management and staff updated and reviewed this regularly.

Care plans were personalised, holistic and recovery orientated. On Haven ward supporting documentation included 'one page profiles' and communication passports, these provided a wealth of information specific to each patient. Positive behaviour support plans and care plans clearly indicated how patients wanted staff to meet their specific needs. Staff updated and reviewed care plans regularly. However, the number of care plans for each patient remained extensive, there was some repetition within the range of care plans and there was limited integration of the multi-disciplinary aspects of care.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice.

Staff followed National Institute for Clinical and Healthcare Excellence guidance, alongside recommendations from the Royal College of Psychiatrists; when prescribing medication. Staff followed best practice guidance for 'stopping over medication of people with a learning disability, autism or both with psychotropic medicines.' (STOMP)

Staff ensured patients had good access to physical healthcare. Patients had a comprehensive physical health examination and assessment upon admission. The hospital had a team of professionals dedicated to meeting the physical health needs of patients, including; registered general nurses, nutritionist, occupational therapist, physiotherapist and a general practitioner. The general practitioner attends the hospital regularly and all patients are registered with them. Staff referred patients to specialist services when required, these included chiropody, diabetes clinic, dentist and ophthalmology.

Good

Forensic inpatient or secure wards

Six of the patient care records we reviewed, indicated patients had long term physical health conditions, such as asthma and diabetes. We found there were no records of reviews of their health condition by a suitable clinician for three of these patients.

Staff assessed and met patients' needs for food and drink. Patients received screening for the risk of malnutrition and staff used a recognised screening tool. Care records reviewed demonstrated that staff recorded and monitored the nutritional and hydration needs of patients. This proactive approach ensured patients' physical health needs were being met.

Staff supported patients to live healthier lives. The hospital nutritionist worked with patients and staff to improve dietary intake and lifestyle choices. Alongside the nutritionist, patients met regularly with the catering team to develop healthier meal choices. In addition, the hospital reviewed the provision within the hospital shop and reduced the availability of sugar-based drinks and snacks.

To increase levels of physical activity, patients had access to outdoor space and physical activities such as walking and football. The hospital gym provided a range of activities; including weekly bootcamp sessions. The hospital provided smoking cessation information and treatment.

Interventions and treatments recognised by National Institute for Clinical and Healthcare Excellence were promoted alongside medication regimes. The service used a range of nationally recognised outcome measures and rating scales. These included Health of the Nation Outcome scales; Model of Human Occupation Screening Tool and the Liverpool University Neuroleptic Rating scale. Staff used these tools to monitor and measure clinical and occupational interventions and side effects of medication. Staff completed outcome measures regularly and these were monitored through the hospitals governance framework.

Staff provided patients with access to a range of psychological and occupational interventions. Patients received a comprehensive multi-disciplinary risk assessment, covering a range of activities within the hospital and community. These included meal preparation, domestic tasks and community based activities. We observed patients working in the hospital shop, café and library. On Haven ward we observed a range of interventions used to engage and support patients with sensory and communication needs. These included story boards and talking tiles.

Positive behaviour support plans aim to enhance the quality of life as both an intervention and an outcome for people that display behaviour that challenges and those that support them. In the care records reviewed we saw that patients with and without a learning disability had positive behaviour support plans which were adequate, providing general information. Each plan included primary, secondary and tertiary interventions relating to behaviour. This meant that staff had the right information available to them to support and effectively manage behaviour that challenges. Positive behaviour support plans included the use of reactive strategies, such as restrictive interventions.

Patients had access to psychological services through a psychology team based within the hospital; including three forensic psychologists, three trainee psychologists, one psychology assistant and one cognitive behavioural therapist. Psychology staff provided a range of offence related treatment programmes; addressing thinking skills, sexual offending and fire setting. Psychology worked with patients in groups and on an individual basis. Patients were allocated to the most appropriately skilled psychologist in relation to individual patient need. For example, staff were trained in schema focussed therapy, dialectical behaviour therapy and eye movement desensitisation and reprocessing. Psychology staff facilitated reflective practice groups, this supported staff to think in a psychologically informed way, particularly in key areas such as risk.

Staff used technology to support patients effectively. The hospital made good use of technology to support communication needs on Haven ward; talking tiles were used to support patients. These were recording devices that could be used as verbal reminders or prompts to patients. Haven ward used a touch screen notice board to provide information for patients, including an explanation of their rights under the Mental Health Act. The communication and media team within the hospital produced a series of animations, screen savers and videos to provide information to new staff and support patients.

Staff completed a range of audits to monitor and improve the quality and safety of care. These included care plans, risk assessments, supervision, health and safety and application of the Mental Health Act. Nursing staff audited

medicines and related documentation regularly. The hospital monitored audit activity and outcomes through the governance structure. Staff discussed outcomes and actions in staff meetings and ward managers at individual ward reviews with senior managers.

Skilled staff to deliver care

The hospital had access to a comprehensive multi-disciplinary team. These included a consultant psychiatrist, junior doctors, nurses, support workers, advocacy and administration. Alongside this, the hospital had an extensive team of allied health professionals. These included occupational therapists, psychologists, speech and language therapist, nutritionist, physiotherapist and social workers. Staff could also access additional specialist knowledge and support through the hospitals Mental Health Act lead.

Staff were experienced and qualified and had the specialist skills to meet the needs of the patient group. Ward managers told us there had been changes in leadership across some of the wards. Aire, Brook and Don had new ward managers, although all were experienced staff from within the service, the hospital recognised time was required to establish these roles and support was provided accordingly.

The hospital recognised a large proportion of staff were in their probationary period and this remained high risk on the strategic risk register. As of 08 July 2019, 15.4% of staff were in their probationary period. From April 2019 the hospital introduced a range of measures to mitigate this risk, including an employee engagement forum and seeking feedback from new staff at three and six months during their probationary period. Alongside this, the human resources department were sighted on where all probationary staff were based within the hospital; workforce data charts used colour as a visual prompt for easy identification. In preparation for future recruitment, the hospital had completed a review of the skill set required for future applicants and how this can be assessed at interview.

The hospital employed both registered mental health and learning disability nurses, they received specialist training as part of their university training. Healthcare support workers received some specialist training, this included learning disability, autism, epilepsy, dementia and personality disorder.

Managers provided staff with appropriate induction, this included a range of on-line training and face to face training sessions. The hospital provided a two week induction for all staff, including agency staff. The induction programme covered a comprehensive range of topics including risk management, security, safeguarding, relational security, health and safety and environmental and personal searching. Senior managers delivered sessions on the vision and values of the organisation and expectations of staff conduct.

Staff had opportunities to develop their skills and knowledge. Staff told us the hospital supported them to access a range of training opportunities specific to their roles. Some staff had been supported to attend university to complete nurse training and the hospital were currently supporting 13 staff members to complete the trainee nurse associate programme.

Managers ensured eligible staff received an annual appraisal of their performance, 82% of staff had had an appraisal within the last 12 months. The doctors we spoke with during this inspection confirmed they had an annual appraisal.

Staff received regular supervision appropriate to their role. Staff did not raise any concerns about not being able to access supervision. Between 01 January 2018 and 31 December 2018, the hospital recorded a rate of 78% for clinical supervision. Esk ward recorded the highest compliance rate at 99% and Brook ward the lowest; at 49%. In the June 2019 meeting of The Clinical Effectiveness, Compliance and Audit Committee, staff acknowledged there was a need to improve the clinical supervision rate. The hospital maintained oversight and progress of supervision activity; as senior managers reviewed this regularly during individual ward reviews with ward managers.

The hospital was in the process of implementing a knowledge and skills framework for nursing staff, to be used alongside appraisal and supervision. The aim of this approach is to ensure the hospital has a structure to engage and monitor staff in a positive manner.

Staff; including healthcare support workers, nurses and members of the multi-disciplinary team had access to regular team meetings, governance meetings and reflective practice sessions.

Managers dealt with poor staff performance promptly and effectively. Managers told us staff contracts were terminated when probationary periods were not successful.

Multi-disciplinary and inter-agency team work

Multi-disciplinary meetings were held regularly. Daily handovers on all wards and the hospital morning business meeting were held to review the previous 24 hours care and discuss individual patients, treatment and risk. We observed one hospital morning business meeting and it was evident that staff had the opportunity to discuss operational issues and share information regarding patient care. Staff reviewed outstanding actions from the previous day, such as incident forms and allocated these for completion. Staffing, scheduled meetings and maintenance for the day were also discussed. The meeting had purpose and value for those staff attending.

Multi-disciplinary team meetings were held weekly across all wards to review patients' care, treatment and discharge plan. Clinical, nursing and allied health professionals attended meetings. The independent mental health advocate and carers attended multi-disciplinary meetings to support patients and ensure all viewpoints were represented. Care co-ordinators from community teams were also invited to attend multi-disciplinary meetings. We observed one multi-disciplinary team meeting on Don ward. The meeting was well attended by staff and included a social worker external to the hospital.

Working relationships between teams within the hospital were effective. Following the introduction of the hospitals Quality Strategy 2019-2021, a clear governance framework is developing. Within this, a range of committees and sub-groups have been created to assess and monitor the quality and safety of care. This approach has brought together staff and patient representatives from across the hospital to work collaboratively. Patients spoke positively about this experience and one staff member told us their sense of being part of the entire hospital had increased, as opposed to working on just one ward. Some allied health professionals felt there was still progress to be made in establishing their role within the hospital, however, staff were optimistic in achieving this. One staff member told us there remained a minority of established staff that had yet to embrace the new ways of working within the hospital, although they were confident progress was being made.

The hospital had established effective working relationships with teams outside the organisation, such as primary care, education, public protection unit, social and community networks. The hospital meets on a quarterly basis as part of the 'Overarching Safeguarding Enquiries' group. This is attended by the local authority, police, commissioners and the CQC.

Adherence to the MHA and the MHA Code of Practice

As of 28 February 2019, 90% of staff within the hospital had received training in the Mental Health Act. This training was mandatory for staff in specific roles. The training compliance reported during this inspection was lower than the 95% reported at the last inspection. The Mental Health Act lead also provided bite-size training sessions for staff across the hospital on specific topics; including updates and changes to legislation. The Mental Health Act lead was a member of the northern regional mental health group and Mental Health Act managers group, this ensured practice remained up to date and support received from a wider relevant resource.

Staff had access to administrative support on implementation of the Mental Health Act and its Code of Practice and staff knew who this was and how to contact them. The hospital had up to date policies and procedures and these were easily accessible via the intranet. Staff stored copies of patients' detention papers and associated records appropriately and these were available to staff when they needed to access them.

Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice guiding principles. Staff told us they would access support from the wider clinical team and the Mental Health Act office, as they were confident in the depth of knowledge and understanding available.

The hospital had access to an independent mental health advocacy service. Staff told us they visited the hospital regularly and supported patients on a one to one basis and in meetings; including ward rounds and care programme approach meetings. Information was displayed on each ward about the advocacy service. Feedback from the advocacy service was mixed. Concerns related to short notice requests to attend multi-disciplinary meetings, low referral rates from staff, no standard requests to support patients in seclusion and the merger of the learning disability wards. However, the service acknowledged the

progress made by the hospital including; use if easy read material, availability of occupational and social activities and an improved, cleaner environment. The advocacy service told us patients engaged well with the service, complaints had decreased, and the service had easy access around the hospital.

Staff informed patients of their rights under the Mental Health Act. Staff on Haven ward had copies of easy read versions of patients' rights and could use these to explain the process to patients. Care and treatment records recorded when patients received their rights under the Mental Health Act, and staff completed these at regular intervals. Staff had requested an opinion from a second opinion appointed doctor and the appropriate paperwork was in place to evidence these decisions. Staff completed Mental Health Act documentation audits and managers monitored the outcomes of these audits. However, we noted the hospital seclusion audit tool failed to pick up one late medical review, the late independent multi-disciplinary review and lack of risk assessment for one seclusion episode.

Staff ensured that patients were able to take Section 17 leave and staff told us this was rarely cancelled. Leave for patients was an important part of their care and promoted engagement with the community and prepared patients for discharge. Staff told us Section 17 leave was planned to ensure enough staff were available to support patients.

Staff discussed Section 117 aftercare with patients, records reviewed demonstrated planning for aftercare provision for patients. In our review of care records we noted some overlap between 'My Future Plan' and discharge plan.

The CQC completed five Mental Health Act monitoring visits to the hospital between March and November 2018. Issues identified included records relating to seclusion, capacity to consent to treatment, treatment authority certificates and recording of carer input into care plans. During this inspection we reviewed a sample of these actions and were assured the service had addressed a number of the issues identified and were progressing with others. However, we identified that the hospital policy for mobile phones and mail management was not in line with the Mental Health Act Code of Practice.

Good practice in applying the MCA

Staff understood the Mental Capacity Act and supported patients to make decisions about their care and treatment.

As of 28 February 2019, 90% of staff within the service had received training in the Mental Capacity Act. The service stated that this training was statutory for staff in specific roles. The training compliance reported during this inspection was lower than the 95% reported at the last inspection.

Staff we spoke with had a good understanding of the Mental Capacity Act and its five statutory principles. The hospital had provided staff with a credit card sized guide, this acted as quick glance prompt regarding the five statutory principles.

Care records demonstrated that staff had assessed and recorded capacity assessments for patients who may have impaired mental capacity, these were time and decision specific. We saw evidence of decisions made in a patients' best interest. Staff did not make decisions in isolation relating to capacity, and discussion and decisions were documented in medical and multi-disciplinary reviews. For example, we saw assessment of capacity recorded in care records relating to consent to treatment and attending the general hospital for a procedure and best interest meetings relating to finances. Staff recorded the outcome of assessment clearly in the patients care record. The Mental Health Act office maintained a database to monitor and review capacity assessments, this ensured decisions about patient care were appropriate and current.

The provider had up to date policies and procedures on the Mental Capacity Act. Staff were aware of these and they were easily accessible via the intranet. Staff told us they would speak to managers or the Mental Health Act office for advice on the Mental Capacity Act.

There were no deprivation of liberty safeguards applications at the time of this inspection.

Staff audited the application of the Mental Capacity Act. The outcome of this audit was monitored by the Mental Health Act office and through the Mental Health Act and Mental Capacity Act Committee.

Good

Forensic inpatient or secure wards

Are forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff provided care and treatment with a sense of optimism and positivity. We observed staff interacting with patients in a kind and respectful manner, providing patients with appropriate practical and emotional support. Staff were patient and calm during challenging situations. Except for two patients, who raised concerns about staff attitudes, feedback from patients was positive. Patients felt cared for by staff and felt they had a genuine interest in their wellbeing. We spoke with four carers during this inspection and feedback was largely positive, describing staff as 'good, respectful and helpful.' The hospital patient satisfaction survey in December 2018 recorded an overall patient satisfaction rate at 71%. The majority of patients (79%) felt respected by staff and 77% patients felt staff maintained their privacy.

Staff supported patients to understand and manage their care, treatment or condition. Staff developed individual care plans addressing specific issues such as substance misuse, diabetes, epilepsy and weight management. Staff on Haven ward adapted plans into easy read formats to support patient understanding.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. We noted in care records that staff had referred patients to a range of other services, such as the dentist, opthalmology and the emergency department at the local hospital.

Staff understood the individual needs of all patients. Patient records included a range of documents that provided detailed information addressing the complexity of patients' individual needs. Staff on Haven ward had developed one page profiles for each patient and communication passports. Patients across the hospital also had health action plans and positive behavioural support plans. Collectively, this information informed the development of care and treatment plans addressing personal, cultural, social and religious needs.

At the previous inspection we told the hospital they must ensure the care and treatment of patients with gender identity issues reflects their needs and preferences. Following this staff received training from an external specialist training provider and the hospital introduced a policy for patients with transgender needs. The policy was updated in November 2018; however, it was not written in plain English and did not reference any national sources of information. Information about transgender support groups was not available on the wards.

Staff were confident they could raise concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences. The hospital had a policy to guide and support staff to raise concerns. In addition, the hospital appointed four staff members as 'speak up guardians.' Staff also had access to an external whistle-blowing telephone line to raise any concerns.

Staff maintained the confidentiality of information about patients by securely storing paper based care records. The service had clear confidentiality and information sharing policies to guide and support staff.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orientate patients to the hospital. Staff told us patients toured the ward and were introduced to the wider patient group. Staff provided patients with information about their ward in a welcome pack, these were also available in easy read formats. To support patients with communication needs or those experiencing different levels of acuity, staff have recently developed an animated version of the patient handbook.

Staff involved patients in care planning and risk assessment. Alongside historical narratives, staff observed and monitored behaviour to develop care plans and inform risk assessment. We saw examples in care records of patient specific needs, such as substance misuse and trauma and how changes in patient behaviour could be interpreted to meet individual needs. Staff supported patients to attend multi-disciplinary meetings; including ward rounds and care programme approach meetings. This approach provided patients with the opportunity to share

their thoughts and contribute to discussions about their care and treatment. Patients told us staff offered copies of their care plans, some patients confirmed they accepted these, however, most declined.

Staff communicated with patients so that they understood their care and treatment, including finding ways to communicate with patients with communication difficulties. Staff across the hospital used a range of pictorial and written words within care plans to communicate with patients, including communication passports. Staff on Haven ward used easy read information and pictoral activity planners to strengthen patients' understanding of their daily routines and manage their expectations. Staff had access to a library of accessible information on a variety of topics including testicular cancer, going to court, health and bereavement.

Staff involved patients in decisions about the service, ranging from ward based decisions through to those impacting hospital wide. Each ward had patient representatives across a range of hospital governance groups; including reducing restrictive practice group and patient forum. Patients we spoke with were positive about these opportunities to contribute. Patients had been involved in discussions regarding e-cigarettes, catering and the reduction of patient property. However, one patient told us they did not agree with the recent decision to reduce patient property within bedrooms, they felt this was unfair. Patients and staff worked together during the planning and implementation of Haven ward within the hospital. More recently, patients had supported the introduction of medicine privacy queues, an initiative to maintain privacy of patients during the administration of medication.

Patients could give feedback about the service they received. Each ward held regular community meetings to enable patients to have their say on what was important to them. We observed 'you said, we did' notice board, this documented a list of suggestions from patients and responses from the team. Suggestion boxes were also available on each ward for patients to use.

All patients had access to an advocate, they visited the hospital regularly and supported patients during meetings and on a one to one basis. Staff enabled patients to make advanced decisions; including the refusal of treatment and end of life care.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff valued carer and family involvement and provided the opportunity to contribute to the care, treatment and recovery of patients. This included the opportunity to attend ward rounds, multi-disciplinary meetings and tribunals. Feedback from families and carers we spoke with was mixed regarding their level of engagement with the service. Families and carers told us when it was not possible to attend ward round and multi-disciplinary meetings, they did not always receive updates from staff and that communication could be improved. One carer told us they didn't feel supported by the hospital and communication was poor. Families and carers were aware of the opportunities to engage with the hospital and three family members confirmed they had attended the families forum. We saw strong evidence of family and carer involvement in seven care records; the majority reviewed provided general detail of family and carer involvement in patient care.

The hospital had improved its approach to family and carer engagement and involvement through the 'Families Forum.' We reviewed the minutes for meetings held in May 2019 and June 2019 and noted the planned meetings for the remainder of the year. The forum was well attended by staff from across the hospital, including ward based staff, multi-disciplinary team members, senior managers and four family members. The meeting focussed on a range of topics, including occupational therapy activities, visits and care planning. Up to date information was available to families and carers on the hospitals website; including previous meeting minutes, meeting action plan and a hot button to submit suggestions directly to the hospital for discussion. To support continued family and carer involvement, the hospital provided families with the opportunity to view selected wards within the hospital and provided financial assistance with travel costs for those families that lived a significant distance from the hospital.

Families and carers could provide feedback to the service; informally through staff, through the families forum and completion of carer satisfaction survey on the hospital website.

Good

Forensic inpatient or secure wards

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Bed management

The hospital provided a low and medium secure national resource for patients with mental illness and for those patients with a primary diagnosis of learning disability, who may have behaviours that challenge or other associated complex needs. The service provided information regarding average bed occupancy between 01 September 2018 and 28 February 2019. The service reported an average bed occupancy of 82%. Managers told us they proactively managed the use of beds and held a weekly referral meeting to consider all referrals made to the hospital. The hospital co-ordinated all admissions through the admissions and contracts officer.

Between the 01 March 2018 and 31 January 2019, the average length of stay for patients ranged between 136 days and 1924 days across all wards. Aire ward recorded the shortest average length of stay and Hebble ward (Now Haven) the longest. Patients always had a bed to return to following Section 17 leave.

Between 01 December 2018 and 31 May 2019, 19 patients had moved between wards during their admission. Ward moves were based on clinical decisions. The hospital successfully discharged 21 patients between 01 April 2018 and 31 March 2019. Staff co-ordinated discharges and moves between wards to support a smooth transition.

Discharge and transfers of care

During this inspection there were six patients experiencing a delayed discharge from the hospital. The hospital confirmed five discharges were delayed due to the availability of a suitable placements within the community. One patient had been served notice on their placement at the hospital in February 2019 and the hospital were waiting for the commissioners to identify an alternative placement closer to home.

Staff planned for patients' discharge in an effective way. Discharge planning within all care records was consistent, although content was general. However, we did review some care records that included discharge plans with a strong recovery focus, involving patients, families and community services. Care programme approach meetings were arranged, and we saw evidence that care co-ordinators regularly attended these meetings to support discharge. Staff reviewed discharge plans regularly. During this inspection we observed a multi-disciplinary meeting, staff discussed with the patient the progress made towards their discharge.

Staff supported patients during referrals and transfers between services. For patients on Haven ward, staff completed 'hospital passports' and a 'one page profile', tools to provide important information to care givers in relation to patient need. Staff supported patients to attend the dentist and the local emergency department. During transfers to other services and prior to discharge, staff encouraged future care providers to visit the hospital to engage with patients. In addition, staff supported patients on section 17 leave to visit these services prior to discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had facilities that allowed patients to be comfortable and ensured the care they received maintained their dignity and privacy. All patients had their own bedrooms and were able to personalise these. All bedrooms had an en-suite bathroom, with toilet and shower facilities. Patients also had access to shared bathrooms on each individual ward, these included toilets and a bath. At the previous inspection we told the hospital it should protect patient's privacy and dignity when using communal bathrooms. The hospital responded by introducing 'engaged' signs on all bathroom doors. One patient who regularly used the bathroom told us they did not feel their privacy or dignity was compromised. All patients could store their possessions safely in their bedrooms and additional secure storage was provided by the hospital.

The hospital had a full range of facilities and equipment to support treatment and care, including space for therapeutic activities. There were quiet areas available for patients to use; including an outdoor space on each ward. The hospital also had a pond that patients could visit and maintain. The hospital had a physical health suite to

undertake physical examinations of patients. Patients had access to a gym, café and shop. The hospital had a dedicated visitors room located off the main clinical areas, this was comfortable and appropriate for children to use.

All patients could make private telephone calls and if required, staff supported patients to do this. Patients could use their own mobile phones, unless individual risk assessment indicated otherwise. Patients could also use the ward telephone to make private calls.

Hot and cold drinks were available twenty-four hours a day. A variety of healthier snacks were available to patients, including fruit. Patients could also have their own preferred snacks, and these were stored securely. Staff had individually risk assessed patient needs in relation to accessing ward based kitchens. When assessment did not support independent access, staff supported patients in these areas. Patients provided us with a mixed response regarding the quality of food. Most patients were satisfied with the available choices, however, some patients felt there was repetition in the menu and portions were small. Staff and patients told us they met regularly with the catering team to discuss the menu. Patients told us they sat with their ward staff monthly to share a meal, patients spoke warmly about this and felt this improved their relationships.

Patients' engagement with the wider community

Patients were supported to maintain contact with their community, families and carers. Patients had access to Section 17 leave and individual patient care plans reflected a range of opportunities for patients to engage with the wider community.

Patient activities were meaningful and linked to recovery goals. For example, some patients had individual roles within the hospital, such as working in the hospital shop and cafe. The hospital developed a recovery college for patients, providing a range of practical skills based short courses. Staff supported patients to participate in a range of individual and group activities; including walking, gym, gardening and football. For those patients with unescorted section 17 leave, additional opportunities within the local community included voluntary work, attending college, football training with the local football club and attending local mental health projects.

Following feedback from patients, activities covered seven days, and these extended into the evening. Managers told us there had been significant improvements in the recording and monitoring of purposeful activity for all patients. As of 03 June 2019, Calder, Don, Foss and Haven achieved above the minimum 25 hours of meaningful activity for each patient. Aire, Brook and Esk wards provided the minimum requirement of 25 hours, however patient uptake averaged 19 hours.

Staff supported patients to maintain contact with their families and carers. Patients had access to regular visits, mobile phones and the use of an internet based application to maintain contact with family and friends.

Meeting the needs of all people who use the service

The hospital met the needs of all people who used the service. The hospital was accessible, including a lift for visitors and patients to access the building and first floor.

Staff identified and met the specific communication needs of patients and implemented the requirements of the accessible information standard (Health and Social Care Act 2012). The hospital had a speech and language therapist for assessment of communication needs. Care records included a range of documents that demonstrated how the service provided information to patients in a way they could access and understand. For example, care plans included the use of pictures and words for patients. On Haven ward, daily activity planners provided visual references for patients to use to communicate their needs. Positive behaviour support plans, communication and hospital passports included information regarding non-verbal behavioural indicators, covering a range of feelings. The hospital also made good use of technology to support communication needs; talking tiles were used to support patients. These were recording devices that could be used as verbal reminders or prompts to patients.

During the inspection, we saw information on display on the wards for patients, including information about how to complain and access legal advice in relation to the Mental Health Act. Information was appropriately displayed in pictorial and easy read formats. Information was also available on physical health and wellbeing topics, staff told us that information could be easily obtained in different languages and formats, including easy read and via the internet. Staff told us they regularly used an interpreting service to support the specific needs of patients.

Patients had access to spiritual support; staff supported some patients to attend places of religious worship in the

Good

Forensic inpatient or secure wards

community. In addition, the hospital welcomed and made arrangements for local religious leaders to attend the hospital. Patients had a selection of food options to choose from daily, including culturally appropriate options.

Listening to and learning from concerns and complaints

The hospital received 159 complaints between 01 March 2018 to 28 February 2019. Of these 38 were upheld, 100 not upheld, 14 partially upheld and 7 remained under investigation. In April 2019 the hospital introduced the 'Safeguarding, Whistleblowing and Complaints Committee.' The committee examines complaint reporting and identifies themes and trends. Current themes include e-cigarettes, patient property and conduct of staff.

We reviewed a sample of these complaints from patients and carers, investigations were completed and feedback provided to the complainant. However, we raised concern with the hospital in relation to one specific complaint regarding duty of candour. The hospital responded immediately and appropriately to our concern.

Patients had easy access to complaint forms and these were available in an easy read format. Patients and carers we spoke with confirmed they knew how to make a complaint and were confident to do so. Staff received training at induction on how to manage and escalate complaints. Staff received feedback on the outcome of investigation of complaints in staff meetings.

The service received 119 compliments between 01 March 2018 to 28 February 2019. Positive staff attitude and behaviour accounted for the majority of compliments.

Are forensic inpatient or secure wards well-led?

Good

Leadership

The hospital had leaders at all levels with a variety of skills, knowledge and experience to perform their roles. In January 2019 the hospital successfully appointed a non-executive director; to provide external challenge and support.

Senior managers we spoke with were established within the hospital and their job role. Two senior managers were relatively new to their posts but were establishing themselves within the hospital team. All managers spoke positively about the organisational and peer support available to them.

Most managers had a good understanding of the service they managed and how the teams worked to provide high quality care. Managers were candid about the volume and pace of change across the wider management team within the hospital. Staff acknowledged the need to embed these changes. Staff spoke positively about their leaders, felt supported and listened to. Staff, patients and carers told us managers were approachable.

The provider supported the development of managers and staff through a range of courses and initiatives.

Vision and strategy

In 2018; following consultation with staff, patients and families, the hospital implemented a new mission, key objectives and a range of core values. The hospital identified its mission as 'to do good for others, with the key objectives of 'to care for and champion the need of people who use our services and to support, develop and celebrate the staff who serve them.' The focus for the values of the hospital included;

- Mind and body
- Care and compassion
- Dignity and respect
- Honesty and transparency

The values were consistently displayed throughout the hospital and staff were aware of how they applied to the service and care provided. The hospital was moving towards values based recruitment, to ensure that staff have the right qualities to deliver high quality care. A recent staff survey in June 2019 confirmed the senior managers had successfully communicated the hospital values, with 96% of staff stating they knew the hospital values. We observed how this translated into the delivery of care; staff were focussed, worked inclusively with patients, in a caring and respectful manner.

Culture

Managers at all levels promoted a culture that supported and valued staff. Staff spoke with genuine warmth about their team, immediate managers and senior managers.

Good

Forensic inpatient or secure wards

Staff supported each other within the service and this made a positive difference to staff. Lines of communication were open and honest within the hospital and staff felt listened to. Staff reported strong working relationships with the multidisciplinary team. We saw that staff were committed to their roles and there was resilience within the teams that enabled staff to manage the daily challenges of providing care. Teams worked well together across the hospital and where there were difficulties, managers dealt with them appropriately.

In contrast, the recent staff survey indicated a mixed response from staff in relation to working within the hospital. During this inspection we observed the employee's engagement meeting, where the staff survey was reviewed. Although responses from staff were not negative, senior managers demonstrated a commitment to drill down into the data to explore staff responses and identify ways to move forward.

All staff we spoke with felt able to raise concerns without the fear of retribution. Staff were familiar with the hospitals whistleblowing policy and were confident in using it. Staff were aware of the hospitals speak up guardians and external whistleblowing telephone line.

Staff told us they had opportunities for career progression and the hospital were committed to extending these opportunities to all staff groups, without exception. The hospital celebrated staff success and received a range of rewards. These included salary enhancements for long service, payment of professional registration fees and vouchers at Christmas. Staff also acknowledged the positive impact of a personal thank you from the chief executive. The Chief Nursing Officer in England awarded the chief nurse a gold award for nursing excellence.

Staff told us there were a range of opportunities for career progression; including promotion and professional development.

Governance

The hospital had systems, processes and a range of policies and procedures that ensured managers could accurately assess, monitor and improve the safety and quality of the service, however, these were not always effective. Managers were candid about the progress made and the need to embed systems and processes. Managers were confident they had established solid foundations through the restructure of the governance framework and the development of the quality strategy. Managers had procedures to ensure the service was clean.

The hospital had established a framework of meetings to ensure essential information, such as learning from incidents and complaints, was shared and discussed. Feedback from staff, managers and a review of meeting minutes evidenced how essential information was shared and recommendations from reviews of incidents implemented.

The hospital monitored and reported on a range of key performance indicators such as staffing, training, length of stay and use of restrictive interventions. Senior managers; including the non-executive director attended monthly governance meetings to understand progress and current themes and issues within the hospital. Therefore, managers were aware of key areas for improvement within the service, such as retention of staff and training in physical interventions. The hospital had taken some action to address these issues through targeted recruitment and providing additional reviews for staff in their probationary periods. The hospital also had processes in place to monitor the performance of each ward and a purposeful programme of audits; these improved quality and safety on the wards.

However, systems and process in place were not always effective. Staff did not always keep records of seclusion in line with the Code of Practice and the Mental Health Act audit did not identify this. The mobile phone and mail management policy was not in line with the Mental Health Act Code of Practice, however, this was due for review and staff did not apply any restrictions on patient mail. Training of staff in physical interventions remained low.

Systems and processes were effective at ensuring staff received supervision and appraisal, incidents were reported, investigated and learning identified.

Management of risk, issues and performance

Managers discussed risk with staff and reviewed the hospital wide risks on a regular basis. Each ward had a risk register based within the electronic incident reporting system and the hospital had a strategic risk register. Staff could raise concerns at ward level and this could be escalated by managers during individual ward reviews. We reviewed the strategic risk register and items included

staffing skill mix, physical intervention training, implementation of new clinical governance framework and lack of involvement by patient and families. These matched the issues raised by staff, concerned others and areas of development identified during this inspection.

The hospital had business continuity plans in place that staff could refer to in emergency situations.

Information management

The hospital had effective systems to collect, review and monitor data about the service. This meant data collection was not over burdensome for frontline staff. Managers anticipated this would be more efficient with the introduction of the electronic care record. Managers had access to information to support them in their role relating to the performance of the service, staffing and patient care.

Staff had access to the equipment and information technology needed to do their work. Although care records were paper based, these were organised and accessible. Staff were optimistic regarding the introduction of the electronic patient care record. The hospital used technology to inform and support patient care.

Staff made notifications to external bodies as needed, including the Care Quality Commission and the local authority safeguarding board.

Engagement

The hospital engaged positively with staff, patients and carers. Up to date information was available through several mechanisms. For staff this included team meetings, emails and the hospitals intranet. Managers consulted with staff regarding the development of the service.

In April 2019 the hospital approved its 'Patient Engagement Strategy', providing a framework for future engagement and development. Patients and carers were kept informed and engaged with the hospital through information on notice boards, forums and the advocacy service. Carers had access to a dedicated page and resources through the hospital's website.

Patients and carers had the opportunity to provide feedback about the hospital. Patients could provide feedback through community meetings, patient forums and via patient representatives at governance meetings. Patients had access to suggestion boxes on each ward. Carers provided feedback through the carers survey and through the hospital's website. Managers welcomed verbal feedback about the hospital from families and carers. Feedback about the hospital was used to make improvements, especially in relation to food, community activities and the environment.

Families and carers could meet with members of the senior management and multi-disciplinary team to give feedback during quarterly family forum meetings and staff told us managers provided an open door to facilitate honest discussions.

The hospital engaged with external stakeholders, including commissioners, the local authority and community organisations.

Learning, continuous improvement and innovation

Healthcare providers can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

In 2018 the hospital participated in the Quality Network for Forensic Mental Health Services quality cycle review and achieved 87% compliance with standards for medium secure services and 82% for low secure services. In January 2019 the hospital was reviewed and improvements within the service were noted.

The hospital is one of two UK accredited sites for The International Institute of Organisational Psychological Medicine. In October 2018 the hospital hosted the 5th Convocation and International Conference of the International Institute of Organisational Psychological Medicine.

The hospital is accredited by the British Institute for Cleaning Science and is an approved training site. The hospital achieved this through working collaboratively with both housekeeping staff and patients.

The psychology service within the hospital provide access to an out of hours telephone line for patients. The basis for this is to support patients from a dialectical behavioural therapy perspective. This has proved invaluable to patients during times of crisis.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all relevant staff receive training in the use of physical interventions.
- The provider must ensure staff keep records of seclusion in line with the Code of Practice.

Action the provider SHOULD take to improve

- The provider should review the system for ensuring patients with long term physical health conditions are regularly reviewed by an appropriate clinician.
- The provider should ensure the policy 'Patient Access to Phones and Mail Management' is reviewed as planned.
- The provider should ensure staff record the reason for the use of prone restraint in incident records.
- The provider should ensure staff record when patients and staff have received a de-brief following an incident.
- The provider should review its policy 'Patients with Transgender Needs' and ensure information is available for patients on wards regarding transgender support groups.
- The provider should ensure patient care plans accurately reflect family and carer involvement.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff did not assess and record risk to patients in seclusion in line with the Code of Practice This was a breach of regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff were not trained to use physical interventions. This was a breach of regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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