

Requires improvement

5 Boroughs Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTV06	Warrington	Chesterton Unit Auden Unit Tennyson Unit Marlowe Unit	WA2 8WA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated the forensic inpatient secure units as requires improvement. This was because:

- The service did not always identify and manage risks adequately. Not all patients had comprehensive, complete and up to date risk assessments. Chesterton unit operated blanket restrictions. On Chesterton unit, there were blind spots that were not observable from nursing stations or by staff located in communal areas.
- There were high levels of incidents involving violence, aggression and self-harm on Chesterton unit. Staff were not confident in managing patients' needs. Recruitment and retention were difficult, which had resulted in a heavy reliance on bank and agency staff, and failure to have enough staff to fill every shift.
- Supervision and support for staff was inconsistent and staff were not confident they had the right skills, knowledge and experience to meet the needs of some patients. Staff were not up to date with all their mandatory training.
- Care and treatment did not always reflect current evidence-based practice. For example, Chesterton unit had not fully implemented a recovery-based model of care, and there was no care pathway in place for the treatment of personality disorders.
- Patients were not always involved in the planning of their care. Patients and relatives expressed concerns about how some staff treated patients on Chesterton unit. Some care records contained comments that lacked dignity and respect for patients. Not all patients had discharge plans in place.
- Patients and staff expressed concerns about the suitability of the facilities on some units for meeting the needs of all patients.
- Chesterton and Auden units did not adequately record and deal with complaints received from patients and relatives.
- The governance systems did not identify gaps in service provision and did not produce sustained improvements to the care delivered.

Summary of findings

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

Are services safe?

We rated forensic inpatient secure wards as requires improvement for safe because:

- The layout of the units presented blind spots that were not managed effectively.
- Recruitment and retention of staff was a challenge for the service. This led to a high usage of bank and agency staff.
- Some seclusion records were incomplete.
- There were incomplete or missing risk assessments for patients on Chesterton, Auden and Tennyson units.
- There was a blanket search policy applied to patients on Chesterton unit. The need for this was not recorded in individual care plans.
- There were elements of mandatory training which less than 75% of staff had attended. These included breakaway training, clinical risk assessment and medicines management.
- Learning from incidents was not always shared with staff.

There were ligature points on all units that were well managed with completed risk assessments and identified actions to mitigate the risks. Medicines were stored securely.

Requires improvement



Are services effective?

We rated forensic inpatient secure wards as requires improvement for effective because:

- Patients' care records contained incomplete assessments and care plans.
- The quality of MHA documentation was variable. Records contained gaps, missing information and incomplete forms.
- Staff were not always receiving supervision in line with trust policy.
- The service had adopted a recovery-based model of care, but this was not informing care on Chesterton unit.
- Multidisciplinary team working was not always coordinated sufficiently to provide effective care.

On Marlowe unit, there were adequate support arrangements for staff. Recovery-based approaches underpinned care, and we saw examples of good quality care records. Handovers were effective and comprehensive. A GP and physical health nurse ran weekly clinics to support patients' physical health needs.

Requires improvement



Are services caring?

We rated forensic inpatient secure wards as requires improvement for caring because:

Requires improvement



Summary of findings

- Care records were not always patient-centred and were not written in the first person.
- Patients' involvement in their care was inconsistent across the units and not always evident from their care records.
- Three patients and two relatives expressed concerns about the attitude and behaviour of some staff on Chesterton unit.

However, patients on Marlowe unit gave positive comments about the staff. Weekly community meetings took place on Marlowe, Auden and Tennyson units. Patients were involved in designing publicity for groups, running self-harm workshops and producing a newsletter. All patients received a handbook or information leaflet about their unit on admission. There was a well-publicised advocacy service.

Are services responsive to people's needs?

We rated forensic inpatient secure wards as requires improvement for responsive because:

- Discharge plans were missing or incomplete across all units.
- Staff we spoke with described different ways of managing complaints. Local complaints were not always recorded which meant themes could not be identified.
- Patients and staff expressed concerns about the suitability of the facilities on Chesterton, Auden and Tennyson units for meeting the needs of all patients.

Activities and escorted section 17 leave were rarely cancelled. There was spiritual support available to patients. Some patients had care plans in an easy read formats. There was information for patients on how to complain.

Requires improvement



Are services well-led?

We rated forensic inpatient secure wards as requires improvement for well-led because:

- The systems in place were not effective in assessing, monitoring and improving services. Environmental risks such as blind spots had not been identified, activity records and local staffing records were not accurate.
- There were recurring errors in MHA records.
- Staff morale was low on Chesterton unit.

However, some units were well-led locally, for example, Marlowe unit. Staff morale was good and staff expressed satisfaction with their work.

Requires improvement



Summary of findings

Information about the service

The forensic inpatient/secure units are part of the secure mental health services delivered by 5 Boroughs NHS Foundation Trust. Secure services are based at the Hollins Park Hospital site, and contain four units designated as low secure and step-down/rehabilitation. The service comprises a low-secure unit for women, a low-secure unit for men, a low-secure unit for women with learning disabilities, and a low-secure step-down rehabilitation unit for women.

We inspected all four units:-

Chesterton Unit

20 beds, female, low secure

The unit provides services for women over 18 years old with very complex mental health needs who require specialist inpatient care. All patients are liable to be detained under the Mental Health Act (MHA) 1983.

Marlowe Unit

15 beds, male, low secure

The unit provide services for men over 18 years old with very complex mental health needs who require specialist inpatient care. All patients are liable to be detained under the MHA.

Auden Unit

10 beds, female, low secure

The unit provides services for people aged 18 to 65 who have mild to moderate learning disabilities and mental health difficulties. All patients are liable to be detained under the MHA.

Tennyson Unit

8 beds, female, low secure

The unit provides step-down rehabilitation services for women aged 18 and over. Patients are liable to be detained under the MHA.

This was the first comprehensive inspection of this service undertaken by the CQC. However, the CQC undertook MHA reviews of each unit between October 2014 and January 2015, and provided each unit with a detailed report of the findings from those reviews.

Our inspection team

Our inspection team was led by:

Chair: Kevin Cleary, Medical Director, East London NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Patti Boden, inspection manager, Care Quality Commission; Sarah Dunnett, inspection manager, Care Quality Commission

The team that inspected forensic inpatient/secure wards was comprised of eight people: four inspectors, one Mental Health Act reviewer, one psychologist, one mental health nurse, and one expert by experience.

Why we carried out this inspection

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

Summary of findings

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 the information we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited four of the units at the hospital site and looked at the quality of the unit environment and observed how staff were caring for patients;
- conducted 21 interviews with patients who were using the service;
- spoke with four relatives;
- spoke with the managers or acting managers for each of the units;

- spoke with 23 other staff members including doctors, nurses, an occupational therapist, a psychologist, and a speech and language therapist;
- interviewed the modern matron with responsibility for managing these services;
- attended and observed one community meeting;
- observed two hand-over meetings and four multidisciplinary team meetings.

We also:

- looked at care records for 28 patients;
- looked at incident logs for each of the units;
- looked at Mental Health Act records for 17 patients;
- visited the clinic rooms on all four units;
- carried out a specific check of the medication management on all four units and reviewed 30 prescription charts;
- looked at a range of policies, procedures and documents relating to the running of the service.

What people who use the provider's services say

We spoke with 21 patients and four relatives during the inspection. They gave mixed feedback about their experience of secure services. Comments about Marlowe unit were generally positive. On Chesterton unit, five patients we spoke with and two relatives expressed concerns about the care and safety on the unit. Patients and relatives had mixed comments about Auden unit but two patients and two relatives expressed concerns about safety on the unit.

Patients raised concerns about their safety on Chesterton and Auden units owing to the unit environment, patient mix and staffing levels. Patients complained about the poor quality and quantity of food on all units with the exception of Tennyson unit. On Chesterton unit, patients raised concerns about staff behaviour and attitudes.

Good practice

The service developed and delivered positive communication and empowerment sessions to patients

following concerns about the level of hate-related incidents on the units. The trust's equality and diversity lead developed the programme alongside patients to raise awareness of diversity and inclusion.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that staff complete seclusion and MHA records accurately.
- The trust must ensure that patient records, are complete and accurate and supporting management plans are in place where required. This includes risk assessments, care plans and discharge plans.
- The trust must ensure staff report serious incidents in accordance with trust policy and that learning from incidents is shared with staff.
- The trust must ensure that staff receive appropriate training to perform their role and are up to date with mandatory training.

- The trust must ensure that patients are involved in the planning of their care. Patients must be able to discuss care and treatment choices continually and have support to make any changes to those choices if they wish.
- The trust must ensure that patients are prescribed medicines in accordance with the forms of authorisation.

Action the provider **SHOULD** take to improve

- The trust should adopt a model of care in line with good practice for distinct service areas and relevant to the patient cohort.
- The trust should ensure that complaints are recorded and themes identified so that lessons can be learnt.
- The trust should ensure multidisciplinary teams are effective.

5 Boroughs Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Chesterton unit Marlowe unit Auden unit Tennyson unit	Warrington

Mental Health Act responsibilities

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

The CQC carried out MHA monitoring visits on each of the units between October 2014 and January 2015. These visits were unannounced and identified a wide range of concerns predominantly on Chesterton, Auden and Tennyson units such as:

- an inconsistent approach to advising patients of their rights;
- a lack of evidence to show involvement of patients and carers in care plans;
- issues with leave forms;
- physical assessments for patients not consistently completed;

- recording of assessments of capacity to consent;
- compliance with seclusion protocols;
- suitability of the unit for patients with complex needs;
- staffing levels;
- delays in discharge.

The provider's action plan in response to the issues identified indicated that all issues would be resolved prior to our inspection.

We reviewed these as part of our comprehensive inspection and found that not all the issues had been fully resolved for Chesterton unit, and only partly resolved for Auden and Tennyson units.

Detailed findings

We found that the trust had taken action in respect to some of the issues. For example, the trust had been working with the responsible CCGs and local authorities in relation to the issue of delayed discharges. The units had regular meetings and discussions with external CCGs in relation to the CCGs' responsibilities to provide appropriate placements for patients.

However, we found:

- detention records contained incomplete forms and missing documentation;
- there were errors in section 17 leave forms, and duplicate copies;

- missing assessments of capacity to consent for some patients treated under the authority of a T3 form;
- forms that did not correctly record that staff had explained to patients their rights under section 132;
- incidences of prescribing outside the limits authorised by certificates to consent to treatment.

In January 2015, 88% of staff had received training in the MHA across all four units in secure services. At June 2015, 86% of staff in secure services had received training in the MHA. The rate for Chesterton unit was the lowest of the four units at 75%.

Mental Capacity Act and Deprivation of Liberty Safeguards

All of the patients on the forensic inpatient/secure units were detained under the MHA. As of June 2015, 85% of staff in secure services had received training in the Mental Capacity Act and had a good understanding of capacity issues. In one care record, there was an example of a

discussion about the patient's capacity to make a decision about contraception. On Marlowe unit, the patient's care team discussed issues relating to capacity and raised them at clinical workshops.

Are services safe?

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

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

Our findings

Safe and clean environment

All four units were in reasonably good condition of repair and décor. Marlowe unit had recently undergone a complete refurbishment. All units were clean and tidy. Domestic staff stored cleaning materials in locked cupboards.

Both Marlowe and Chesterton units had CCTV installed in communal areas. The screens were located in the reception areas external to the unit areas. Nursing staff did not use them for day-to-day routine observations, but they were helpful for post-incident analysis.

The trust had undertaken environmental risk assessments on each of the four secure units in June 2015. These highlighted possible ligature risks for each of the units and the trust had taken action to mitigate these risks.

Chesterton unit had 20 beds, which was above the recommended standard of 15 for low secure units. Staff and patients commented on the inadequacy of the unit environment and facilities for 20 patients with mixed and complex needs. Prior to our inspection, the dining room had been temporarily out of use owing to damage. This had limited the facilities available to patients.

The layout of Chesterton ward meant that staff could not easily observe all areas of the ward, and there were limited lines of sight from the nursing station. There were parabolic mirrors throughout the ward, which were partly effective. The unit relied primarily on staff located throughout the unit to monitor these areas and mitigate any risks. We saw staff positioned in the communal area but only the entry areas of the bedroom corridors were visible from there.

On Chesterton and Auden units, posters and notices on the office window partly obscured the lines of sight. On Marlowe unit, there were blind spots throughout the unit with only one parabolic mirror to mitigate the risks, and it was not possible to observe all areas of the unit from the nursing station. On Chesterton unit, there was a blind spot in the seclusion room. We informed the trust and on our return visit two weeks later, we saw they had installed a parabolic mirror in the seclusion room to help mitigate the risks.

Tennyson unit was a step-down rehabilitation unit and did not have a seclusion suite. When patients from Tennyson unit required seclusion they would use the facilities on Auden unit, which was located on the ground floor of the same building.

Safe staffing

The trust provided details of current minimum staffing levels for the four wards based on a staffing assessment it had undertaken in May 2014. This was due for review in December 2014, but was delayed.

The total staffing establishment for the four secure units was:

- 48.6 whole time equivalent (WTE) qualified nurses;
- 67.8 WTE unqualified staff.

On 30 June 2015, there were 5.2 WTE vacancies for qualified staff and 5WTE vacancies for unqualified staff.

The staffing levels by unit were:

- Chesterton unit – 38.95 WTE qualified and unqualified staff posts;
- Auden unit – 34.6 WTE qualified and unqualified staff posts;
- Marlowe unit – 34 WTE qualified and unqualified staff posts;
- Tennyson unit – 14.8 WTE qualified and unqualified staff posts.

Vacancies by unit were:

- Chesterton unit – 3 WTE posts for qualified staff and 4 WTE posts for unqualified staff;
- Auden unit – 1 WTE post for qualified staff;
- Marlowe unit – 1.2 WTE posts for qualified staff and 1 WTE post for unqualified staff;
- Tennyson unit – 1 WTE post for unqualified staff.

In April 2015, the units were staffed to the safe staffing levels with a combination of regular and bank and agency staff. The trust had offered temporary staff short term contracts to ensure that staff who were familiar with the patients and units were used.

Are services safe?

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In June 2015, the trust had identified concerns on Chesterton unit. The unit was placed on the service's risk register and the concerns were shared with the specialist commissioners who had then visited the unit and produced a report which confirmed the vacancy rate, staff turnover and low morale as a concern. The service manager had implemented an action plan, and we saw that action had been taken. Chesterton unit was a high priority for recruitment, the unit manager had returned from secondment, the number of deputy manager posts had been increased to three and extra bank staff were used to ensure safe staffing levels. Staffing rotas and the director of finance confirmed this. However, there were some long term actions which remained outstanding. Recruitment to the deputy manager posts was ongoing and psychology support for staff caring for patients with a diagnosis of personality disorder was planned to start in September.

When required staffing levels were increased to help reduce risks and manage patient care, for example, in early July 2015, four patients received care on a staff to patient ratio of 1:1.

During April, May and June 2015, 256 shifts on Chesterton unit were filled by bank or agency staff and 63 shifts were not filled. The unit reported difficulties in filling shifts during the day and the staffing rotas showed there were occasions where there was only one qualified nurse on duty.

The system for recording staff on duty was confusing as there were separate systems for recording regular or bank staff and agency staff.

In June 2015, Auden unit's vacancy rate was 3% and the average sickness rate for permanent staff was 4%. The trust judged the safe staffing level for day and night shifts as six staff for the day shift, five staff for the afternoon shift and four staff for the night shift. The unit manager and staffing rotas confirmed this staffing level. During April, May and June 2015, 155 shifts were filled by bank or agency staff and 21 shifts were not filled.

In June 2015, Marlowe unit's vacancy rate was 7% and the average sickness rate was 4%. The trust judged the safe staffing level for day and night shifts as six staff for the day shift, five staff for the afternoon shift and four staff for the

night shift. The unit manager and staffing rotas confirmed this staffing level. During April, May and June 2015, 146 shifts were filled by bank or agency staff and 21 shifts were not filled.

In June 2015, Tennyson unit's vacancy rate was 7% and the sickness rate for permanent staff was 9%. The established staffing level for day and night shifts was three staff for the day shift, two for the afternoon shift and two for the night shift. The unit manager and staffing rotas confirmed this. During April, May and June 2015, 186 shifts were filled by bank or agency staff and 14 shifts were not filled.

We reviewed the trust's training programme for the four secure units. This comprised three components: statutory training, core training and specialist training. Core training included information governance training and basic life support training. Specialist mandatory training included risk management, local induction, breakaway, clinical risk assessment, medicines management, Mental Capacity Act (MCA), MHA, dual diagnosis, care programme approach (CPA) and clinical supervision.

On 30 June 2015, 81% of staff had completed training against the trust's target of 85%. However, training rates varied across the individual components and units.

Breakaway training teaches staff how to avoid or escape from an assault, and avoid harm to either staff or patients. The rate for breakaway training across the units was low, ranging from 44% on Chesterton to 78% on Marlowe. Specialist commissioners had recently identified as a concern that bank health care workers did not receive training in breakaway techniques. This meant there was a risk of there not being enough staff trained to restrain people, which put patients and staff at risk of injury. There was a risk also that it increases pressure on the staff team because it reduced the total number of staff who could respond to incidents.

Care Programme Approach (CPA) training was low on all units, ranging from 15% - 46%. The number of staff trained in medicines management, dual diagnosis and clinical supervision was between 0% and 23%.

On Chesterton unit, there were a number of components where the number of staff trained was below the trust's target of 85%:

- Fire training 64%
- Infection control 72%

Are services safe?

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- Basic life support 69%
- Information governance 64%
- Breakaway 44%
- Clinical risk assessment 44%
- Mental Capacity Act 75%
- Mental Health Act 75%
- Dual diagnosis 8%
- CPA 25%
- Medicines management 0%
- Clinical supervision 6%

Staff and patients on Chesterton Unit reported that activities were cancelled occasionally because of insufficient staffing or because of incidents on the unit. For example, two patients told us of occasions when their leave was cancelled. In one case, a patient's medical appointment was cancelled because of staff shortages. This was re-arranged and the patient had attended by the time of our return visit two weeks later. Staff told us they re-arranged cancelled leave at the earliest opportunity. Staff recorded cancelled leave on patients' daily records but not as incidents on datix.

Staff supported their patients in seclusion facilities on other units if there was not one on their unit, or if theirs was in use. For example, a patient on Tennyson ward used the seclusion suite on Auden unit, which was located on the ground floor of the same building. Staff and patient used the lift to go to the ground floor, where staff from Auden unit met and escorted them to the seclusion suite. Staff from Tennyson unit then supported the patient while they remained in seclusion. On another occasion, a patient from Chesterton unit used the seclusion suite on Auden unit. The practice of transferring patients to, and supporting them in seclusion rooms on other wards meant there were fewer staff left to provide care on the units. This was also the case when units diverted staff to help other units during incidents or staff shortages.

Assessing and managing risk to patients and staff

We reviewed trust data on the uses of seclusion between 1 October 2014 and 31 March 2015. During this period, Auden and Chesterton units reported the highest numbers of uses of seclusion across the trust. Auden unit reported 36 incidents of seclusion and Chesterton unit reported 24.

Further data for Chesterton unit showed that in the three months from April to June 2015, the use of seclusion had increased to 28 occasions. Tennyson unit used the seclusion unit on Auden unit on 19 occasions.

There were no incidents of long-term seclusion reported during this period.

Some seclusion records were not completed accurately. We reviewed five seclusion logs on Chesterton unit and found missing information in three of the five.

- One log stated 'unknown' for the date when the seclusion ended and medical officer (MO) informed field. Staff had identified this and taken action to address this.
- The second log was missing entries for the date when the seclusion began. This log was also missing detail of the events leading up to the seclusion and the report by the MO on duty. The staff had not completed the audit tool following this episode of seclusion.
- The third log had missing entries for 30-minute observations; staff had not completed the seclusion ending report. Staff had identified these errors in the audit tool.
- One incident report on 30 June 2015 indicated that the incident had been followed by an episode of seclusion. We checked the seclusion log, but there was no reference to this seclusion incident or any seclusion event on that date.

We reviewed the data on the use of restraint for April, May and June 2015. Across all four secure units, there were 115 incidents of restraint, of which eight were in prone position and 24 resulted in rapid tranquillisation. The numbers of incidents of restraint reflected the patient mix and risk assessment and management on each unit. For example, incidents of restraint were relatively low for Marlowe and Tennyson units (four and seven respectively). Staff on Marlowe unit knew their patients well and actively sought to identify warning signs and triggers in their patients and to avoid escalation. Their care records clearly identified risks, triggers, warning signs and methods for responding to patients. However, on Auden unit, which is a 10-bedded low-secure unit for people with learning disabilities, there were 56 incidents of restraint reported over the same three-month period. Of these, six involved restraint in the prone position and 10 involved rapid tranquillisation. A recent report by commissioners had identified that restraint records were poorly recorded when they visited. We reviewed five restraint records and found they were completed appropriately including a description of events, the reasons for the use of restraint, use of de-escalation techniques and the low-stimuli room. Chesterton unit,

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which is a 20-bedded low-secure unit for women, reported 48 incidents of restraint during the three-month period. Two of these were in prone position and 13 resulted in rapid tranquillisation.

Specialist commissioners had identified concerns regarding the quality of care records on Chesterton. In total, we examined care records for 28 patients across all four units. The quality and content of patient care records varied. For example, on Marlowe unit, we reviewed nine patient records, which contained completed and up-to-date care plans, risk assessments, physical health assessments, and a speech and language therapy assessment for a patient with swallowing difficulties. Most contained evidence of discharge planning. In addition, there were specific assessments for identified physical needs, for example diabetes and hypertension. However, on Tennyson unit, we reviewed four care records, all of which contained incomplete documents. These included incomplete admission assessment forms and missing discharge plans for two patients.

The quality and content of risk assessments also varied. Staff assessed patient's risks on admission.

The service used the Historical Clinical Risk management assessment tool (HCR 20), which is a comprehensive set of professional guidelines for the assessment and management of violence risk. However, its use across the secure units was inconsistent. On Marlowe unit staff had completed and kept risk assessments up-to-date. However, on Chesterton and Auden units we found nine risk assessments that were not completed, current or signed.

There was good medicines management practice on all units, in line with best practice guidelines. Medicines were stored safely, staff checked fridge and room temperatures daily, and the emergency equipment weekly. However, on Marlowe unit, although emergency drugs were stored safely, they were not easily accessible. They were stored on the top shelf of a locked cupboard, to which only qualified staff held keys.

The trust had a self-medication policy and procedure that linked to the step-down rehabilitation remit on Tennyson unit. At the time of our inspection, all patients on Tennyson unit were preparing for discharge but none of the patients were managing their own medication. However, staff gave an example of a former patient who had managed their own medication.

The staff on Chesterton unit searched all patients regardless of risks on return from leave, which was a blanket restriction. The trust took this action in response to identified risk but this was not included in individual's care plans.

The staff on Marlowe unit obtained the consent of the individual to be searched and there were completed forms for each patient in the search area.

Staff were trained in safeguarding adults and children. In June 2015, 97% of staff had completed safeguarding adults training and 93% for safeguarding children training. Eighty-five percent of staff had received level two safeguarding children training. Staff completed web forms to log safeguarding concerns, and submitted them to the unit manager who managed the process thereafter.

There was a trust policy for managing visits by children. There were separate facilities for visiting children and families on all units with the exception of Tennyson unit who could use the family visiting room on Auden unit. Visitors also used any available room on the unit subject to the procedures set out in the Tennyson unit handbook.

Track record on safety

Trust data from 1 May 2014 to 30 April 2015 showed that there were four serious incidents requiring investigation on the secure units (out of 100 serious incidents for the whole trust). These included one allegation against a healthcare professional, one absconson, one serious self-harm injury and one serious incident.

In contrast, the number of incidents logged at unit level on the trust's incident management system (datix) was high. The policy was for datix entries to be reviewed and then shared with external agencies where appropriate. The number of incidents identified as serious, and reported via the serious incident framework by the central risk team was low.

We reviewed the incident log for a three-month period (April - June 2015). There were 479 incidents logged for all secure units, of which eight were also noted as safeguarding concerns. This indicated an effective reporting of incidents locally and an open culture.

Chesterton unit, which provided 38% of the beds in secure services, reported 216 incidents, which was 45% of all incidents. Of these, three incidents were also recorded as safeguarding concerns. We identified the most frequent

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locations for these incidents: 64 occurred in communal areas, such as the corridor and lounges; 56 occurred in patients' bedrooms; and 36 occurred in the clinic room. We also looked at the most frequent types of incidents. There were 88 incidents of violence and aggression: 63 incidents involved patient to staff harm and 22 incidents involved patient-to-patient harm. There were 65 self-harm incidents, 30 medication-related incidents and 20 incidents related to patient care, such as delays to treatment and attendance of medical staff. Sixty incidents occurred during the hours of 9pm and 8am. The most frequent locations were: patients' bedrooms with 23 incidents, and communal areas of the unit, such as the lounges and corridors, with 26 incidents. The types of incidents during these hours were predominantly violence and aggression, and self-harm.

Auden unit, which provided 19% of the beds, reported 138 incidents which was 29% of all incidents. Of these, three incidents were recorded as safeguarding concerns. We reviewed the most frequent locations for these incidents: 45 incidents occurred in the corridor, 26 incidents occurred in the patients' bedrooms, 24 incidents occurred in the lounge/dining area, and 18 incidents occurred in the low-stimuli room. We also looked at the most frequent types of incidents. There were 57 incidents of violence and aggression, 39 of which involved patient to staff harm and 16 involved patient-to-patient harm. There were 53 self-harm incidents, 30 medication-related incidents and 10 incidents related to patient care, such as delays to treatment. We looked at the occurrence of incidents during the hours of 9pm and 8am. There were 38 incidents in total. The most frequent types of incidents were self-harm (21), violence and aggression (13).

We reviewed the incidents on Tennyson unit, which provided 15% of the beds in secure services. In the past, Tennyson had experienced fewer incidents than other units, which reflected that it was a step-down rehabilitation unit. For the three-month period ending June 2015, Tennyson unit reported 56 incidents, which was 11% of all incidents. The majority of these incidents were associated with one patient. There were two safeguarding concerns noted. The most frequent locations for incidents included the corridor (14), patients' bedrooms (14), and the lounge/dining room (9). There were 22 incidents of violence and aggression, 18 of which involved patient to staff harm. There were 17 incidents of self-harm. There were 10 incidents between the hours of 9pm and 8am, of which eight were self-harm incidents.

Three out of six patients we spoke to said they did not think Chesterton unit was safe. Patients told us that the unit had deteriorated in the past two months. They expressed fear of other patients, described tension on the unit, and said they were "waiting for it to kick off." One patient said she locked herself in her room to stay safe, as "you have to watch your back." Another patient said she went to the nursing area to be near staff and help them keep her safe. Other patients expressed a mistrust of staff and frustration at inconsistencies in their approach to patients.

Staff and management confirmed the unit was experiencing difficulties, and gave a number of reasons, including patient mix and complexity, staffing levels, staff skill mix, environment, training, management and the model of care. Management was developing plans to address some of these issues. In addition, staff had referred three patients to medium-secure units for assessment.

Reporting incidents and learning from when things go wrong

Our review of the data showed inconsistencies in incident and safeguarding reporting. Staff knew what to report on datix, but serious incident reporting on STEIS was a separate process managed outside the service. Staff noted safeguarding concerns when reporting incidents on datix but this was not consistent. Staff also completed a separate electronic communication form for safeguarding incidents. These went to the ward manager and staff were unsure how referrals to the local authority were generated. Trust data showed that for a 12-month period ending 31 July 2015, staff had completed 126 communication forms across the four secure units. This resulted in 27 adult safeguarding referrals to the local authority.

Not all staff were debriefed following incidents. On Marlowe unit, there were regular debriefs following incidents. On Chesterton unit, staff reported they did not receive debriefs following incidents although unqualified staff tried to support each other when time permitted. However, handover meetings included discussions of incidents. Multi-disciplinary meetings also included discussions about incidents as part of the patient's care review, but these meetings did not include unqualified staff.

There was no evidence of staff on Chesterton unit receiving feedback from the investigation of incidents. One unit manager accurately described good practice in learning from incidents, but confirmed it did not occur on some of the units.

Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

Pre-admission assessment was thorough. Staff completed admission documents for all new patients, which contained a physical health screening assessment, a psychiatric review and a risk assessment.

We reviewed nine care records for patients on Marlowe unit. We found comprehensive assessments and care plans for their individual needs. Patients with specific health issues were referred to, and received input from, the appropriate health professionals, including a speech and language therapist, a dietician and a diabetes nurse. The unit ran a substance misuse group.

We reviewed seven care records on Chesterton unit and found that records had not been fully completed. We found:

- incomplete risk assessments and physical health assessments
- absence of discharge plans and risk management plans
- unsigned and undated document
- care plans that had not been updated for some time
- one care plan indicated a patient was in seclusion but this was not the case
- another care plan said, "according to BNF, there are side effects to the medication you have been prescribed." However, the care record did not include what the medication was and the side effects.

We reviewed records for four patients on Tennyson unit we found:

- one record contained reference to recovery but this was not completed
- a discharge plan with no nursing care plan.
- a patient with no discharge plan.
- A care plan had not been updated since admission to the unit in April 2015.

The service used paper records and an electronic care records system called OTTER. The service gave us conflicting information about what information was available on each file. We checked both paper and electronic files. Despite having a member of staff to support us it was difficult to locate documents on all units except

Marlowe unit. On Chesterton unit, not all permanent staff were trained to use OTTER, which meant they had to ask other staff for access to information and feedback on patients' care.

A GP held weekly clinics on each unit. A physical health nurse, employed by the trust for the secure units, supported the clinics.

Smoking cessation sessions were in place. Rolling 12-week courses started in May 2014, in preparation for full implementation of the no smoking policy in 18 months' time.

Best practice in treatment and care

The service employed a physical health nurse. A GP held a surgery on a weekly basis.

On all units, the service offered patients dialectical behavioural therapy (DBT) on a group and individual basis. Staff referred patients to psychology. However, there were often waiting lists for assessment and intervention. The psychology service was undergoing a restructure with the aim of allocating psychologists to specific units, with changes to be made by September 2015. A specialist psychologist in personality disorders was joining the service in September 2015 for three days a week to support staff and help implement personality disorder strategies and training. Training on personality disorders was in development with the aim to roll it out from September 2015.

The Health of the Nation Outcomes Scales (HoNOS) were used throughout the service.

The trust had adopted a recovery-based model of care but this was not consistently applied across the units. There were examples of good implementation on Marlowe unit whereas Chesterton unit showed little compliance. For example, we saw copies of Recovery Star and My Shared Pathway on patients' files but some were blank or incomplete. The unit had recognised this gap and had started to hold recovery workshops for patients to help embed Recovery Star within the unit.

In addition to the poor implementation of the recovery-based model of care on Chesterton unit, the unit had no specific models of care associated with their complex mix of patients and diagnoses, such as personality disorder, paranoid schizophrenia, and Asperger's Syndrome. For

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example, there was no personality disorder strategy to help manage the needs of patients on Chesterton unit. However, the trust had plans to adopt a personality disorder strategy and train staff.

Skilled staff to deliver care

At the time of our inspection, Chesterton unit was experiencing challenges, which were included on the trust's risk register. As well as staffing levels and environmental factors, the trust had identified staff skills and patient acuity as the main issues affecting the unit. One of the challenges experienced by the unit over the past 18 months was the change in patient mix. The modern matron had recently undertaken an audit and found that 75% (15 out of 20 patients) had a primary diagnosis of personality disorder. This presented additional challenges to the service and staff, for which they were not adequately prepared. For example, there was no personality disorders pathway in place, and staff did not feel skilled to manage the patients' needs effectively.

We reviewed the list of specialist training available to staff on the secure units. Staff, management and the trust acknowledged there was a limited range of courses offered. In particular, there were gaps in skills for managing personality disorders and self-harm behaviour.

The courses offered during 2014/15 included:

- Recovery Star training in January 2015. There were eight attendees, seven from Auden unit and one from Chesterton unit.
- Clinical risk and HCR 20 in December 2014 and February 2015. There were seven attendees, five staff from Auden unit, one from Marlowe unit and one from Chesterton unit.
- Managing self-harm workshop in February and March 2015. There were five attendees, three staff from Chesterton unit, and two staff from Auden unit.

During 2014/15, Marlowe unit had held a nurse development day. The Essential for Forensics Programme was a bi-monthly rolling programme, which had not taken place since May 2014. The service manager advised us this would recommence in the near future. Staff did not receive separate training on searching patients but this was included in control and restraint training.

Prior to 2011, staff had access to courses on cognitive behavioural therapy, personality disorder, drug awareness, women's mental health and enhanced forensic skills. The trust had not offered these courses since.

Sessions on the use of the electronic care records system (OTTER) continued to be offered in 2014 and 2015.

Not all staff were receiving regular supervision which was not in line with the trust policy.

During the period October 2014 and March 2015 the highest rate of supervision was:

- Chesterton 66%
- Auden 47%
- Tennyson 71%
- Marlowe 49%

However, during our inspection, staff on Marlowe unit told us they received regular 1:1 supervision. Staff on this unit also had access to weekly clinical workshops and fortnightly recovery-focused workshops and staff meetings. There were opportunities for reflective practice, case reviews and discussion of presenting issues.

Most staff had received appraisals. The percentage of non-medical staff on the secure units who had received an appraisal in the last 12 months was 81%.

Chesterton and Auden units had the highest number of staff who had not received appraisals at 25%.

Multi-disciplinary and inter-agency team work

Multidisciplinary team (MDT) work varied across the four units. On all units, MDT meetings took place weekly and reviewed each patient on a fortnightly basis.

On Marlowe unit, the MDT worked well. It comprised a range of disciplines including psychiatry, psychology, occupational therapy, nursing and speech and language therapy. Support workers, administrative staff and the unit housekeeper were welcome to attend the meetings. The unit had close working relationships with the forensic outreach team, who supported discharge planning and community leave.

On Chesterton unit the MDT had recently introduced a new model of working. The MDT meeting did not include unqualified staff. Unqualified staff had the possibility of passing information onto a nurse who attended the meeting. MDT members attended the handover on Chesterton unit weekly to explain MDT decisions about

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patients' care and promote a consistent approach to patient care. At this meeting the inconsistent approaches to managing patients on the unit was discussed to ensure time was put aside for reflective consideration and to develop confidence and competence. However, this was not always happening.

At an MDT meeting we attended on Auden unit, the psychologist reported that staff had not followed their advice to undertake daily mindfulness sessions with one patient.

Handovers were effective. They contained detailed discussion of all patients, handover sheets, and all staff participated. We observed a handover on Chesterton. Staff gave a comprehensive handover, which included physical and mental health issues. Staff knew the patients well and discussed them respectfully. Staff used a handover file and comprehensive handover sheet.

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

MHA monitoring visits took place on each of the units between October 2014 and January 2015. These visits were unannounced and identified a number of issues as follows:

Chesterton unit:

- inconsistent approach to advising patients of their rights;
- lack of evidence to show involvement of patients and carers in care plans;
- issues with leave forms;
- issues with seclusion protocols;
- physical assessments for patients were not consistently completed.

Tennyson unit:

- issues with recording assessment of capacity to consent;
- issues with seclusion protocols;
- suitability of the unit for patients with complex needs;
- staffing levels;
- delays in discharge.

In addition, the MHA monitoring review identified that assessments of capacity were not always recorded on

Marlowe unit, and found issues with leave forms and staffing levels on Auden unit. The provider had submitted provider action statements to the CQC stating what improvements it would make in response to the identified issues, and the timescales for doing so. The timescales suggested the issues would be resolved prior to our inspection.

We reviewed these issues as part of our comprehensive inspection and we found they were not fully resolved.

On Chesterton we reviewed five files and found:

- one file was missing detention documents but there were renewal records in place;
- duplicate copies of the same section 17 form;
- none of the section 17 form were signed by patient;
- none of the patients were given copies of their section 17 form;
- one patient had no section 17 risk assessments;
- one patient had identified as a condition of section 17 leave "ensure personal living space is tidy prior to leave commencing".

On Tennyson unit we reviewed seven files and found:

- two files were missing detention documents;
- one patient had no capacity of consent recorded at time of first treatment;
- two files where the patient was treated under the authority of a T3 form were missing the assessment of capacity to consent;
- all records contained evidence that staff explained to patients their rights under section 132. In six of the files the forms did not record this correctly.

On Auden unit, we reviewed five files and found:

- detention and renewal papers were in place for all patients;
- in three records there was no assessment of capacity to consent to treatment by the responsible clinician.

On Marlowe unit, we reviewed 12 medication charts and found:

- One patient on a certificate of second opinion (T3) form was prescribed a combination of medication above the BNF 100% limit for the class of drugs. The T3 form clearly authorised this class to 100% BNF. This meant that patient was at risk of being administered medication not approved on the T3 form.

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- One patient on a certificate to consent to treatment (T2) form which allowed for two anti-psychotic medications was prescribed three. This meant that the patient was at risk of being administered medication not approved on the T2 form.

In January 2015, 88% of staff had received training in the MHA across all four units in secure services. At June 2015, 86% of staff in secure services had received training in the MHA. The rate for Chesterton unit was the lowest of the four units at 75%.

Good practice in applying the Mental Capacity Act

At June 2015, 85% of staff in secure services had received training in the MCA. The rate for Auden unit was 82%, Chesterton unit was 75%, Marlowe unit 82% and Tennyson unit 100%.

In one care record, there was an example of a discussion about the patient's capacity to make a decision about contraception.

On Marlowe unit, the patient's care team discussed any issues relating to capacity and raised them at clinical workshops.

Are services caring?

Requires improvement 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

Patients and relatives gave mixed views on the behaviour of staff to units them. Patients on Marlowe unit were positive about the staff and said staff treated them with kindness and respect. On Marlowe unit, we observed good respectful engagement between staff and patients. Staff respected the privacy and dignity of patients attending clinic rooms. Staff knew patients well which helped develop good staff and patient relationships. In one case, staff supported a patient to renew his wedding vows. There was a 'you said, we did' board on the unit. Patients on Auden and Tennyson units also said they had good relationships with the staff and said staff knew them well.

On Chesterton unit, most patients we spoke with raised concerns about staff behaviour and attitudes. There were times when patients did not feel well supported or cared for. However, one patient expressed sympathy for staff working in such a challenging environment. One relative commented that staff seemed "quite nice" but communication between staff and relatives was poor. The relative described a noisy environment and a lack of privacy when visiting on the unit. Another relative said they were "disgusted" with the care and they had witnessed disrespectful attitudes from staff. On two occasions on Chesterton unit, inspectors observed that staff interaction with patients was cool and dismissive.

On Chesterton, Auden and Tennyson units, care plans were not written in a person-centred way. At times, staff wrote in the second person, for example, "you are..." which sounded discourteous. Some comments in care plans lacked dignity and respect towards patients, for example, we found comments such as "you are morbidly obese", "your lack of communication may cause you to become frustrated",

On Auden unit, care plans were not written in a format that the patient would understand, and it was not clear what actions had been taken to ensure that patients were involved in, and understood their care plans.

Weekly community meetings took place on Marlowe, Auden and Tennyson units. Chesterton unit did not have community meetings but during our inspection had commenced a 'check-up' meeting with patients.

The involvement of people in the care that they receive

We saw some good examples of patient involvement but this was generally limited across the services. On Chesterton unit, a patient was running a self-harm support group, and patients were involved in setting up workshops to promote Recovery Star. One patient was involved in designing the publicity for the positive communication and empowerment programme. Patients were involved in producing a newsletter, "The Mag" for secure services.

Seven out of eight care plans on Marlowe unit showed good evidence of patients' involvement in their care. Staff asked patients to sign their care plans and offered them copies. Patients helped decide their activity programmes at weekly patients' meetings. Staff adopted a collaborative approach to care and focused heavily on building working relationships with patients. For example, Marlowe unit allocated each patient a recovery worker (healthcare worker) to support his or her individual recovery plan. Staff discussed patients' assessed needs and risks and explained all treatments and interventions.

We reviewed seven care plans on Chesterton unit and found only two plans that showed any patient involvement. One patient told us they were involved in care planning and decisions about their care.

On all units, patients received a unit handbook upon admission, which was informative and comprehensive. It contained information about activities, advocacy, complaints, and unit rules and procedures. However, patients' experience differed from that stated in the handbook, both positively and negatively. For example, the handbook referred to patients having one hour of bedroom access after lunch and dinner if they engaged in activities. In practice, patients had full access throughout the day to their rooms. Patients on Tennyson unit bought their own food as part of their rehabilitation plan. The handbook stated that food could not be stored in their rooms but they would have access to the kitchen.

Relatives were invited to attend multidisciplinary team meetings on all units, but not all were offered copies of care plans. At an MDT meeting on Auden unit, staff said patients and carers were not given copies of care plans because only one printed copy was available, in line with trust policy.

Are services caring?

Requires improvement



By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We saw there were carers' meetings scheduled on a bi-monthly basis from August 2015, and a learning disability forum scheduled for September 2015. Chesterton unit was hosting a carers' day on 5 August 2015.

Advocacy services were provided by Advocacy Together for Mental Wellbeing.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

During 2014, the average bed occupancy rate for all four secure units was 90%. Chesterton, Auden and Marlowe units had a bed occupancy rate of more than 95%. The trust rated the bed occupancy rate across mental health services as a risk. During April, May and June 2015, the average bed occupancy remained at 90%. The actual bed occupancy rates were 100% for Auden unit, 94% for Chesterton unit, 87% for Marlowe unit and 77% for Tennyson unit.

Chesterton unit contained 20 beds. At the time of our inspection, there were 18 patients on the unit.

Patients transferred between units during their admission as part of a planned pathway of care. However, in one case, a management decision resulted in a patient's transfer from Auden to Tennyson unit, the step-down rehabilitation unit. Managers described the patient as ready for discharge and discharge arrangements had been made. However, staff were nursing the individual on enhanced observations due to the complex nature of their needs. This was affecting the other patients on the unit.

There were 24 patients discharged during the 12 months to 30 June 2015. The average length of stay for these patients was one year and nine months (622 days). Tennyson unit, the step-down rehabilitation unit, discharged five patients in the 12 months prior to our inspection. The average length of stay for these patients was one year and eight months (591 days).

For the six-month period to 31 March 2015, there had been 10 delayed discharges in secure units. On 23 July 2015, there were seven delayed discharge patients in secure units. Of these, three patients were waiting transfer to beds in other hospitals and four patients were waiting for public funding. The length of delay of discharge ranged from 74 to 277 days. Two patients had been waiting 74 days and five patients had been waiting in excess of 225 days. Staff reported it was common for patients to deteriorate during the delayed discharge period preventing their discharge.

On Tennyson unit, we found two patients' records in which there was an absence of discharge planning documentation or incomplete discharge plans.

The facilities promote recovery, comfort, dignity and confidentiality

All units offered adequate surroundings and a range of facilities. However, staff and patients raised concerns about the suitability of the facilities for meeting the needs of the number, complexity or mix of patients on the units.

Marlowe unit was a 15-bedded unit for men. The unit environment was calm and pleasant. The unit contained a lounge, a dining area, activities of daily living (ADL) kitchen and a gym. The chairs were comfortable and there was artwork displayed on the walls. There were five en suite bedrooms and ten rooms with shared bathrooms.

Chesterton unit was a 20 bed unit for women. Eight out of 20 bedrooms were ensuite, the remaining twelve shared communal bathrooms. The unit comprised a small TV lounge, a large dining room with a small courtyard, activity room, ADL kitchen and a lounge. Access to the ward was via an air lock, which led to the dining room. Access to the activity, dining and quiet rooms was controlled for safety reasons. The staff allowed patients to access these areas as required. The gym was out of use and being used as a storage area. At the time of the inspection, the unit environment was loud, noisy, bright and busy. The external areas of Chesterton unit were messy, and there were cigarette butts on the floor. The area of the unit with unlimited access for patients was relatively small for the number of patients.

The service had recognised that the patient mix and unit environment on Chesterton unit was presenting challenges for meeting the needs of the patients and managing risks. The trust was considering options to improve the unit, for example, splitting the unit into two and developing an extra care (low-stimuli) area.

Auden unit was a 10 bed for women with a learning disability. The unit contained an open lounge/dining area, an activity room, an activities of daily living (ADL) kitchen. There was a low-stimuli room on a noisy and busy corridor, which echoed loudly when in use.

Tennyson unit was an eight bed unit for women. All bedrooms had en suite bathrooms. The unit was well maintained with a good standard of décor and furnishings. The unit contained a dining room/kitchen, laundry, clinic room, lounge and one multifunction room. The unit used the multifunction room as a low-stimuli room, visiting room, phone room and interview room. Staff controlled

Are services responsive to people's needs?

Requires improvement 

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

access to some areas by keeping rooms locked for safety reasons. Staff allowed access to these areas on request. Some patients expressed concern about these restrictions on a step-down rehabilitation unit.

There was no privacy for phone calls if using the public phones. However, staff facilitated privacy for calls where possible, for example, staff transferred calls to another room or offered a cordless phone, if available. On all units, patients had access to their own mobile phones.

Hot and cold drinks were not available throughout the day and night on all units. Patients on Chesterton and Auden units had restricted access to hot drinks. Hot drinks were only available on an hourly basis throughout the day (outside of breakfast time) through a trolley service. Patients complained about this and told us there was often not enough milk, which caused tension amongst patients. On Tennyson unit, hot and cold drinks should have been available from the dining room/kitchen throughout the day and night. However, patients could not enter the dining room when it was in use. During our inspection, there was a ward round taking place in the dining room.

Patients were able to personalise their rooms on all units. There were facilities for safe storage of valuable items. On Chesterton unit, patients placed items in a box allocated to them, and these were stored in a lockable cupboard on the unit. Patients on Marlowe and Tennyson units had a safe in their rooms.

Each unit had access to occupational therapists (OT) and activities assistants. There were four OTs employed across the four secure units. The OT staff offered activities six days a week on Marlowe, Chesterton and Auden units. However, patients on Chesterton unit said staff cancelled activities if there were not enough staff to support them. At a ward round we attended, we heard that staff were struggling to facilitate 2:1 leave for a patient on Chesterton unit.

There was an OT vacancy on Tennyson unit, and three different activities assistants worked on the unit three days a week. Because of this, patients reported a lack of coordination and consistency in planning and managing activity programmes. However, many of the patients on this unit received unescorted leave and took part in activities away from the unit.

We reviewed trust data for therapeutic activities that took place in April, May and June 2015 on three of the secure units. There was no data provided for Tennyson unit.

During the inspection, the occupational therapist told us there had been issues with accurate data collection for 25-hour meaningful activities. The service only recorded activities supported by an occupational therapist or activity assistant. This had meant that leave, therapy groups, psychology sessions and activities supported by unit staff were not included in the data. As such, the data was potentially unreliable for forming judgements about the levels of meaningful activity patients experienced.

For example, the data showed that 17 patients from three wards had received an average of three hours of activity during the month of April 2015, and 21 patients from three wards had received an average of two hours of activity during the month of May 2015. On review of the data for June 2015, we found a wide variation in the level of activity undertaken across the wards with Marlowe ward showing the highest engagement from patients and relatively low levels for Chesterton and Auden wards.

Marlowe unit records showed that patients were offered in excess of 25 hours of activity each week. There was a range of indoor and outdoor activities available according to patient preference and risk assessment. Outdoor activities included fishing, cycling, walking, pool, and swimming. There were trips planned to Blackpool and a local football stadium. The unit gym was not used because patients preferred to use the gym in the local community. Indoor and on-site activities included healthy eating and cooking sessions, barbeques and football. One patient was doing voluntary work in the local community. Patients and staff reported that cancellation of leave and activities happened rarely on Marlowe unit.

There were separate facilities for visiting children and families on all units with the exception of Tennyson ward where visitors used any available room on the unit. However, units had limited facilities to accommodate visitors in cases where patients could not leave the unit. For example, one relative expressed concern about the lack of privacy during visits on Chesterton unit. For example, they used the dining room, and were frequently disturbed.

The PLACE scores for Hollins Park hospital site included the secure units.

- Cleanliness 99%
- Food overall 96%
- Unit food 99%

Are services responsive to people's needs?

Requires improvement 

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

- Organisation food 90%
- Privacy, wellbeing and dignity 95%
- Condition, appearance and maintenance 92%

Clinic rooms on Chesterton, Auden and Tennyson units did not contain examination couches. If treatment required a patient to lie down, this happened in their bedroom. On Chesterton unit, there was a small GP clinic room, which contained an examination couch.

Meeting the needs of all people who use the service

On Auden unit, there were example easy read care plans in patients' records.

There was a chaplaincy service on-site, which offered spiritual support and services and activities. Staff had contacted local priests to help meet the specific religious needs of a patient.

There were bathrooms, which had been adapted for people living with disabilities on Marlowe, Chesterton and Auden units.

On Marlowe unit, staff and patients confirmed that activities and leave were rarely cancelled. However, on Chesterton unit, staff occasionally cancelled patients' activities and escorted leave, these were rearranged as soon as practicable.

Patients on all units with the exception of Tennyson complained about the quality and quantity of the food. Patients on Tennyson unit did their own cooking. Some patients complained about choice, quantity and quality of the food. However, the PLACE score was 96% for food overall.

Multidisciplinary team meetings took place on a two weekly basis on all four units. Two patients and one relative complained there was minimal access to the psychiatrist on Chesterton unit in between ward rounds to sign off changes to leave. The psychiatrist was based on the Chesterton unit but at the time of inspection, he was covering two additional units owing to annual leave and vacancies.

Listening to and learning from concerns and complaints

All units displayed information about advocacy and complaints for example, patient advice and liaison service. However, on Tennyson unit, because of the risks presented

by one patient, staff removed all notices from the noticeboard. Complaints information was included in the unit's handbook for patients. The noticeboard on Marlowe unit did not contain information about PALS but this was included in the unit's handbook.

On Chesterton unit, two patients told us they knew how to complain but said there was "no point" as complaints just got lost. Another patient told us she had sent her complaint directly to the trust rather than lodge it at unit level. Three relatives told us they had made complaints about the care and safety of patients on Chesterton and Auden units. We were unable to locate these complaints in the trust's complaints register.

We reviewed the trust's complaints data. The trust received 228 complaints during the 12-month period to 30 June 2015. Of these complaints, eight related to forensic mental health services. Three complaints were upheld, four were partly upheld, and one was dismissed. One complaint was open at the time of our visit. No complaints had been referred to the ombudsman.

Four of the eight complaints were about the attitude of staff on Chesterton unit, two of which were partly upheld.

Two complaints were from groups of patients on Tennyson unit who expressed concern about the impact another patient was having on their recovery. These complaints were upheld.

We asked units how they managed complaints and received inconsistent information. On Marlowe unit, there were very few complaints. We tracked one complaint from Marlowe unit and noted that it was logged on the trust's complaints register. On Marlowe unit, patients were encouraged to raise issues at community meetings, and there were notes taken of these meetings.

However, on the other units, complaints made by patients and relatives were not routinely referred to, or logged onto, the trust's complaints register. The service said it managed unit level complaints locally in line with the trust's policy. Staff said they noted complaints in daily records and passed any written complaints to the unit manager. A senior manager stated that staff logged all complaints onto the datix system. We reviewed datix and saw no evidence of complaints logged onto it with the exception of those that were reportable as incidents.

Are services responsive to people's needs?

Requires improvement 

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

On Chesterton unit, we asked to see a local log of complaints and issues raised by patients and relatives. This

was not available because the unit did not keep a log of complaints and outcomes. However, a team leader informed us that the unit intended to develop a complaints log in the near future.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

The majority of staff were aware of the trust's vision and values. In general, staff reported feeling isolated from the trust. At a local level, staff reported there was frequent contact with unit managers and the modern matron was visible on the units. Two of the units had received recent visits from board members as part of the directorate walk arounds.

Good governance

Whilst overall attendance at training was good, there were some elements where the attendance of staff from specific units fell below the trust target. The trust had provided training for staff on Chesterton on the management of self harm in October and November 2014. The modern matron and ward manager acknowledged that specialist training was required especially for Chesterton unit given its patient mix and acuity, and that the trust had plans in place to deliver bespoke training.

Supervision was inconsistent across all units and was of particular concern to staff on Chesterton unit given the challenges it was experiencing. The unit manager acknowledged this was an issue and was drawing up a supervision schedule. Chesterton unit had recently commenced regular staff meetings. However, a psychologist ran a drop-in supervision session but this was not well attended.

The appraisal rate for the secure units was good with 90% of staff having received an appraisal at the end of June 2015.

The trust reported incidents locally onto datix. There were relatively low levels of serious incident reporting (STEIS), that is, four serious incidents in a 12-month period attributable to the secure wards. A review of the trust's procedures indicated that serious incidents were not recorded onto STEIS soon after they occurred. In practice, there were three gateways before the trust determined whether the incident was reportable to STEIS. These were initial investigation, discussion of findings at a patient safety committee, and decision by the risk manager. As such, we could not be assured that all serious incidents were being reported appropriately.

Following significant concerns about safety on Chesterton unit, the service managers escalated their concerns, which the trust added to its risk register.

Leadership, morale and staff engagement

Marlowe and Auden units had permanent managers in post. The manager of Auden unit also managed Tennyson unit although plans were in place to recruit a dedicated manager for the unit. A temporary post holder had managed Chesterton unit for eight months while the substantive post holder was on secondment. Following the concerns raised about Chesterton unit, the trust had asked the substantive unit manager post holder to return to her post, and she had done so three weeks prior to our inspection.

Staff morale was low on Chesterton unit. Members of the multidisciplinary team commented that working on Chesterton unit was stressful and challenging. Staff acknowledged that the trust had recently taken action with the return of the ward manager, increase in staff and weekly team meetings.

Staff on Chesterton unit said they used handovers as a way of obtaining information in the absence of other mechanisms such as supervision and team meetings. Staff knew how to raise concerns and most staff were confident in doing so.

The sickness rate was in line with the national average for health services with the exception of Tennyson unit, which was at 9%.

Staff we spoke with told us that they were aware of the trust's whistleblowing policy, and they knew how to raise concerns.

Marlowe unit was well-led. Staff morale was good, and staff expressed satisfaction with their work. Staff on Auden and Tennyson units reported there was good team working and mutual support.

Commitment to quality improvement and innovation

The service participated in national audits. The service had identified concerns and shared these with commissioners. The service developed plans in response to identified issues and it was recognised that these would take effect in the long-term.

Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The trust participated in the CPA audit on care delivery on 31 October 2014. The aim of the audit was to assess the trust's compliance with the CPA using the national validated audit tool.

The trust participated in the Quality Network for Forensic Mental Health Services 2015 peer review. The trust developed an action plan in response to the issues identified by the peer review.

The service worked with the trust's equality and diversity lead to develop and implement the positive communication and empowerment programme, which aimed to raise awareness about diversity and inclusion. Sessions had commenced and a further 35 were planned across the secure units.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care <ul style="list-style-type: none">Patients were not always involved in the planning of their care. Involvement was not clear in some care plans and some patients told us they did not feel involved.Two patients were prescribed medicines which were not included on the forms of authorisation (T2/T3). This was a breach of regulation 9(3)(b)(c)(d)(6)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ul style="list-style-type: none">Risk assessments were not always undertaken, complete or updated on Chesterton, Auden and Tennyson units. This was a breach of regulation 12(2)(a) <ul style="list-style-type: none">Learning from incidents was not embedded across the service to ensure that all staff received feedback.Environmental risks were not always managed effectively. There were blind spots on units and in a seclusion room. This was a breach of regulation 12(2)(b)(d)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- The systems in place to monitor the quality of care being delivered were not effective or were not being used. Audits were not identifying shortfalls in quality.
- The recording of patient activities was not accurate.
- There were separate records of staff working on the unit, which meant that local records did not always reflect the names of staff who were working.
- Patient records were not always complete. This included seclusion records and MHA records. There were duplicate copies of MHA records on Chesterton unit.

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Not all staff had received the training needed to perform their role. Bank health care assistants did not have breakaway training.

This was a breach of regulation 18(2)(a)