Inadequate

Humber NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

RV936
Willerby Hill
HU13 9NW
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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)
RV936	Willerby Hill	Greentrees	HU13 9NW
RV936	Willerby Hill	Ouse	HU13 9NW
RV936	Willerby Hill	Swale	HU13 9NW
RV936	Willerby Hill	Darley House	HU13 9NW
RV936	Willerby Hill	Derwent Ward	HU13 9NW
RV936	Willerby Hill	South West Lodge	HU13 9NW
RV936	Willerby Hill	Ullswater	HU13 9NW

This report describes our judgement of the quality of care provided within this core service by Humber 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.

Summary of findings

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
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

We rated The Humber Centre forensic and secure inpatient wards as inadequate because:

- Staff had limited understanding of the use of seclusion. Staff did not always use seclusion in line with the provider's policy or the Mental Health Act code of practice. When we reviewed the seclusion records, we found that that they were not in line with hospital policy.
- Emergency medicines were not available on all wards as per the provider's policy. Staff did not fully complete medication administration records, including for some critical medicines.
- Staff did not understand their roles and responsibilities and withheld patients' incoming mail. There is no power for a medium secure hospital to withhold patients' mail. This is not in line with the Mental Health Act code of practice.
- The environment on some of the wards was in a poor state of repair. The resources needed to maintain the hospital properly were not in place. Furnishings were ripped in places, floors contained trip hazards and paint was flaking off the walls. The fixtures in some of the shower rooms were rusting, there was no ventilation and they had a musty odour. The outdoor courtyard on one ward was covered in moss and littered with cigarette butts.
- Staff did not receive regular supervision in line with the provider's policy. The trust target for staff completing their mandatory training was 75%. However, only 45% of staff had completed this at the time of the inspection. Training in the Mental Health Act was not mandatory and staff had not received training in the revised Mental Health Act code of practice.
- Staffing levels did not always meet the minimum requirements to keep people safe. Staff shortages were not responded to adequately. On occasions, staff cancelled patients' home leave and healthcare appointments due to insufficient staff on duty. One patient had been waiting at least six months to receive treatment recommended by the responsible clinician.
- Mental Health Act documentation was not always complete or in order. Managers had not put good systems in place to ensure staff complied with the Mental Health Act. Staff did not regularly review and update patients' risk assessment on all wards. Care programme approach reviews did not always happen within identified timeframes.
- The management team did not monitor systems and processes to ensure patients received effective care and treatment. Not all staff understood their responsibilities under the duty of candour.

However:

- Staff treated patients with dignity and respect. Staff understood the needs of the patients and involved them in the planning of their care. Each ward held regular patient meetings. Staff involved carers in patients' reviews and held carers meetings. Carers spoke positively of the care provided by the staff.
- Staff morale was good and staff felt supported by their immediate managers. Staff spoke of a supportive multi-disciplinary team and handovers were effective. The ward managers organised team days to involve staff in the development of the service.
- Staff measured risk using recognised tools and used the supportive engagement policy to manage individual patient's risk. Staff received a security induction based on the recognised principles of 'See, Think, Act.' Staff regularly undertook environmental risk assessments.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- The wards were operating at below agreed staffing levels. Staff and patients reported that the wards were often short staffed which meant that section 17 leave was frequently cancelled. Staffing roster's confirmed that wards were often short staffed. This limited patients' access to the community and their families. Section 17 leave is where a patient is able to leave the hospital for a certain period of time whilst detained under the Mental Health Act.
- Staff did not always assess and review patients' identified risks at the frequency recommended in the trust policy.
- Staff had a limited understanding of the use of seclusion across all wards. Staff did not always adhere to the trust policy or the Mental Health Act code of practice when secluding patients.
- Staff did not always fully complete medication administration records.
- Emergency medicines were not available on all wards as per the provider's resuscitation policy
- Managers did not demonstrate best practice or follow trust policy as staff across all wards observed patients opening their mail. If a patient refused, staff would withhold the patient's mail. A medium secure hospital has no power to do this and it is not in line with the Mental Health Act code of practice.
- The environment on some of the wards was in a poor state of repair and required updating.
- Compliance with mandatory training was low at 45% against a trust target of 75%.

However:

- Staff used the supportive engagement policy to manage individual patient's risk.
- Managers used bank staff that were familiar with the wards and patients.
- Staff were undertaking a reducing restrictive practice review.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Mental Health Act documentation was not always complete or in order.
- Staff did not read patients their rights at the frequency indicated in their care plan.
- There was a lack of audit of Mental Health Act documentation.

Summary of findings

- Staff did not take the necessary action to improve outcomes for patients. A patient had been waiting for at least six months to receive treatment recommended by the responsible clinician.
- Staff did not receive regular supervision in line with the provider's policy.
- Training in the Mental Health Act was not mandatory and compliance with Mental Capacity Act training was low.
- Clinical staff did not regularly participate in clinical audits.
- The multi-disciplinary team had vacancies in psychology, social work and a vacant activity worker post, which affected the staff's ability to provide effective care.
- Staff did not always clearly document when they made a decision about a patient's capacity and consent to treatment.

However:

- Patient records contained personalised up to date care plans.
- Staff held regular and effective multi-disciplinary meetings with patients.
- Staff engaged in effective daily handovers to review patients' risk and need.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness and respect and had a good understanding of patients' needs.
- Staff involved patients in their care plans and ensured they played an active role in multi-disciplinary team meetings.
- Families and friends spoke positively about the care staff provided to patients.
- Staff invited carers to attend patients' reviews and held carers meetings to maintain good levels of communication.
- Staff sought feedback from patients at regular meetings and via the friends and family test and patient experience survey.
- Patients had regular access to advocacy.
- Patients were involved in the recruitment of staff

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There was a lack of space on some wards for staff to have one to one time with patients.
- Patients provided varied feedback about the quality of the food and meal times had little flexibility.
- Patients reported limited access to activities.

Summary of findings

- Staff reported activities did not always link to treatment goals for patients and that staffing levels were not sufficient to meet the therapeutic needs of the patient group.
- The service did not monitor patients' engagement in activities or if planned activities were cancelled.

However:

- There were no delayed discharges.
- Facilities were available to engage patients in meaningful activity to support treatment and care.
- Patients knew how to complain and felt comfortable doing so.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Managers did not take a cohesive approach to monitoring the effectiveness of systems and processes.
- Staff reported a disconnect with senior management.
- Staff did not know the trust's vision and values.
- Staff did not always clearly document lessons learned from incidents or share them with staff across the wards.
- There was a lack of audit programme to monitor care and treatment.
- Managers reported a lack of sufficient administrative support.
- Multi-disciplinary staff reported a lack of involvement in research and innovation.

However:

- Staff spoke of good morale at ward level and felt supported by their immediate managers.
- The wards measured themselves against the Quality Network for Forensic Mental Health Services.
- The wards reported on four commissioning for quality and innovation targets

Summary of findings

Information about the service

The Humber Centre for Forensic Psychiatry is a purpose built hospital at Willerby Hill in Hull. Humber NHS Foundation Trust runs the hospital. There are seven inpatient facilities based on this site. It is registered to take up to 80 patients who have been detained under the Mental Health Act 1983. The Humber Centre provides medium and low secure care for mentally disordered or learning disabled male offenders, and men with a personality disorder who require assessment, treatment and rehabilitation within a secure environment.

- Derwent ward provides care for up to 10 male patients with complex mental health problems, who require high levels of support, assessment and intervention.
- Ouse ward provides care for up to 14 male patients who require less intensive support than those on Derwent ward. Staff focus on working with patients to enable them to move on to the next stage of their care.
- Swale ward provides care for up to 15 adult male patients with personality disorders that are functionally linked to their offending and risk behaviours.
- Ullswater ward provides care and treatment for up to 12 male patients with a learning disability and a diagnosed mental disorder.
- Greentrees ward provides medium secure facilities for up to 16 male patients who may be seen as a risk to others.
- Darley House ward supports up to nine male patients who have not made the anticipated progress within traditional low secure services and may have been involved with services for a number of years,
- South West Lodge is a secure community preparation unit. It provides individually graded levels of independence, supervision and security.

At the time of inspection, Derwent ward had 10 patients, Ouse ward had 11 patients, Greentrees ward had 15 patients, Darley House ward had eight patients, Swale ward had 14 patients, Ullswater ward had eight patients and South West Lodge had one patient. For the purpose of this report, the trust submitted data on Greentrees ward, which included South West Lodge. As the staff team worked across both buildings, the trust did not always identify it as a separate ward. Due to this, we refer to seven wards in some data and six wards in others.

The Care Quality Commission (CQC) last inspected the forensic and secure inpatient services in 2014 under the current CQC methodology. There was one breach of regulation 15 (premises and equipment) which resulted in one requirement notice. At the time of this inspection, Humber NHS Foundation Trust reported they had made the required changes.

Our inspection team

Chair: Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected the forensic inpatient and secure wards comprised two inspectors, one consultant psychiatrist, one registered mental health nurse, one Mental Health Act reviewer, and three social workers.

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 information that we held about these services, asked a range of other organisations for information and sought feedback from 11 patients and seven carers at focus groups.

During the inspection visit, the team:

- visited seven inpatient wards and looked at the quality of the environment
- spoke with 26 patients and five carers whose relatives or friends were using the service and reviewed feedback left on 19 comment cards
- spoke with the managers of each ward, two modern matrons, the associate medical director and the clinical care director
- spoke with 35 other staff members; including doctors, nurses, occupational therapists and psychologists
- attended and observed three multi-disciplinary meetings, one patient meeting, one staff handover and one staff reflective practice session
- reviewed the prescription charts of all patients
- reviewed 32 treatment records of patients, the Mental Health Act documentation of 15 patients and seven patients' seclusion records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients and their carers spoke positively about the staff. They felt that staff were caring and helpful and did a wonderful job. Staff treated patients with dignity and respect. Staff understood the needs of patients and involved them in the planning of their care. Staff involved patients in their review meetings and patients felt the multi-disciplinary team were supportive and approachable. Patients reported that staffing levels were often low and this impacted on their care. They felt there were insufficient activities and that section 17 leave was frequently cancelled. The service sought feedback from patients and carers in regular meetings. Patients knew how to complain and felt able to do so.

Good practice

Patients were often not local to the area and had been in hospital for a long time meaning they had lost touch with friends and family. Staff supported patients to maintain contact with friends and family using Skype. Patients felt this helped their progress towards recovery.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the environment is clean, well maintained and suitable for the purpose for which it is being used. Seclusion rooms must adhere to the standards as defined in the Mental Health Act code of practice.
- The provider must ensure that staff understand the use of seclusion. Seclusion must only be used when necessary to prevent risk of harm. Staff must adhere to the seclusion policy and this must be clearly documented in seclusion records.
- The provider must review their policies and ensure staff do not withhold patients' mail.
- The provider must ensure there are sufficient staff on all wards to enable patients to access section 17 leave.
- The provider must ensure staff are enabled to attend mandatory training. This is to ensure staff are competent and skilled to meet people's care and treatment needs.
- The provider must ensure staff receive regular clinical and managerial supervision.
- The provider must ensure that staff regularly review and update patients' risk assessments.
- The provider must ensure that staff clearly record when medicines are administered to patients.
- The provider must ensure that Mental Health Act documentation is kept up to date and is fit for purpose.
- The provider must ensure that patients have access to meaningful activities.
- The provider must ensure that managers take a cohesive and proactive approach to monitoring the effectiveness of systems and processes.

Action the provider SHOULD take to improve

- The provider should ensure that staff understand the environmental risk assessments on each ward, that daily checks are undertaken as required and that staff report issues pertaining to room and water temperatures when they are identified.
- The provider should ensure that all equipment is portable appliance tested and that stickers are visible and in date.
- The provider should ensure that staff report all necessary concerns to the local safeguarding team and clearly document this has taken place in patient records.
- The provider should ensure that care programme approach reviews happen within identified timeframes.
- The provider should ensure staff understand how to use the incident reporting system and are clear on what requires reporting.
- The provider should ensure that the sharing of information about incidents and lessons learned is consistent and documented across all wards.
- The provider should ensure that all staff understand their obligations under the duty of candour.
- The provider should ensure that patients are supported to access treatment recommended by medical staff in a timely manner.
- The provider should ensure that patient records are in order to ensure paperwork is easy to locate.
- The provider should ensure that patients are able to attend routine healthcare appointments in the community, such as dentists and opticians.
- The provider should ensure that patients have sufficient access to psychological therapies to aid their recovery and that progress is measured using validated tools.
- The provider should ensure clinical staff take part in regular clinical audits.
- The provider should ensure that staff document clearly in patient records when decisions are made about a patient's capacity or consent to treatment, using the two stage assessment of capacity as recommended in the Mental Capacity Act.
- The provider should ensure patients privacy and dignity is maintained and not display patients' full names on exit doors.
- The provider should ensure that staff feel connected to the senior management and understand how their work fits into the overall aims of the organisation.
- The provider should ensure the wards have sufficient administrative support.

Humber NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Derwent Ward	Willerby Hill
Ullswater	Willerby Hill
Darley house	Willerby Hill
Ouse	Willerby Hill
Swale	WIllerby Hill
South West Lodge	WIllerby Hill
Greentrees	WIllerby Hill

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.

Training in the Mental Health Act was not mandatory for staff. The provider had not trained staff in the revised Metal Health Act code of practice.

All patients appeared to be detained under the correct legal authority. Records indicated that decisions to renew, extend, or discharge the detention of individual patients was undertaken with regard to the provision of the Mental Health Act and the principles of the code of practice. An independent mental health advocate attended the wards weekly to provide support to patients.

The use of seclusion did not adhere to the Mental Health Act code of practice. Patients were secluded to pre-empt risk and behaviour. The code of practice states seclusion should be commenced: 'where it is immediately necessary for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'. (code of practice paragraph 26.103).

Detailed findings

Although patients were detained under the correct legal authority, Mental Health Act documentation was not always present or in order in patients' records. Managers hearing minutes were missing and old T2, T3 and section 17 leave forms were not cancelled. Staff did not inform patients of their rights at the frequency stated in the patients care plan. Staff did not regularly audit Mental Health Act documentation.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy in place for the Mental Capacity Act and Deprivation of liberty safeguards which contained a brief guide for staff. The Trust had recently made Mental Capacity Act training mandatory, and at the time of inspection, 28% of staff had attended this training.

There were no deprivation of liberty safeguards authorisations in place as all patients were detained under the Mental Health Act.

Staff had a basic knowledge of the Mental Capacity Act and gave examples of good practice. Patients records indicated staff held best interest meetings where required. In two patients' records, the two-stage assessment of capacity test was not present. Staff were unable to tell us who the Mental Capacity Act lead was for the Trust.

Inadequate

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

Five of the inpatient wards were located within The Humber Centre. Derwent, Ouse, and Darley House wards were in the older part of the building. Swale and Ullswater wards had been built in 2010 and the environment was generally in better condition. Greentrees ward and South West lodge were in separate buildings a short walk away but on the same site. Each staff member carried a key pouch and an alarm. Staff handed in an identification badge at reception and received their keys on a sealed ring; they had to sign out any additional keys for external doors. Staff accessed a key press on the wards for additional keys such as kitchen cupboards. The shift leader on each ward held the keys to the medicines cabinet and staff would only hand keys to each other in the office, not in patient areas. Staff received a five-day security induction before they were given keys. The induction followed the principles of 'See, Think, Act', (the Royal College of Psychiatrists guide to relational security) and included scenarios of relational security. Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. Each ward had its own security profile and a designated security nurse undertook daily checks of the environment. Staff also counted in and out all cutlery at meal times and kept a record of regular checks of kitchen equipment in a sharps book. A clinical nurse specialist was also the security lead and was based in The Humber Centre and accessible to staff should they have any queries or concerns.

The wards on Darley, Derwent and Ouse were 'L' shaped with the staff office at the meeting point of both corridors. Staff mitigated the risk of blind spots by positioning themselves outside the office to enable sight lines of both corridors. Two-way mirrors were present in some areas. Staff used the supportive engagement policy to closely observe and engage with patients whose risk to themselves or others was heightened. On Greentrees ward the staff office was located away from patient areas, however we observed there were staff members present in all patient areas during our visit. The ward manager for South West Lodge told us that ligature risks in that building were mitigated by only allowing patients to move there who were ready for discharge and not posing any risks of ligature, self-harm or suicide.

Staff had undertaken annual ligature audits on all seven inpatient areas between 05 June 2015 and 11 March 2016. Where ligature risks were identified, the mitigating factor was usually the observation and presence of staff. The ward security profiles identified ligature risks and assigned each one a severity rating and a plan of action to mitigate the risk. In the last inspection in 2014, the provider received a requirement notice because of ligature points in the seclusion rooms on Ouse, Derwent and Greentrees wards. The trust had taken remedial action and these areas no longer contained ligature points.

All patients on Derwent, Ouse and Darley House wards had their own bedroom and access to shared shower and toilet facilities. Patients on Ullswater, Greentrees, South West Lodge and Swale wards had en suite bedrooms. Mental Health Act monitoring visits conducted over the previous year raised concerns about the environment on some of the wards. The environment on Derwent, Ouse, and Greentrees wards appeared in a poor states of repair. The walls, floor, and doors were marked and damaged in places. Flooring edges were not intact and carpets were stained. The trust had replaced the floor on Greentrees ward the day before our visit. The furnishings were old and the décor was tired. Furniture was torn and damaged in places. The environment on Ullswater and Swale wards was significantly better, the décor was brighter, and the ward had a pleasant smell.

Records indicated domestic staff cleaned the wards regularly although certain areas still appeared to be unclean. On Greentrees ward, patients smoked with the door open into the lounge and cigarette smoke could be smelt throughout the ward. There was also a strong smell of urine in one of the bathrooms. The shower rooms on Derwent and Ouse wards had limited ventilation and although the radiator had recently been replaced, rust had developed on some of the fixtures and fittings. The walls were damaged and a section of the door was rotten. The shower rooms were not well ventilated and had a musty odour. Two toilets on Ouse ward were closed as they were

blocked. A shower room on Ouse ward and two toilets on Darley House ward remained closed as they contained ligature risks and required updating. On Ouse and Derwent wards, staff highlighted trip hazards in the flooring and damp on the walls as causes for concern.

A review of the last six monthly infection control surveillance audits for each ward showed that staff frequently raised concerns about the environment. These included stained carpets, damaged furnishings, unclean curtains, and paint flaking off walls. The quarterly matron report from October to December 2015 showed that legionella had been identified in first floor staff toilets at the Humber Centre (non-patient area) during standard annual testing. Bathrooms were isolated and repairs were made to the hot water pump. Follow-up tests for the presence of legionella were confirmed as clear. The quarterly matron report from January to March 2016 identified issues such as the vinyl flooring on Ouse ward having gaps and Derwent ward requiring re-decoration and maintenance in most areas. It also stated that the nursing office carpets on Swale ward needed replacing urgently as patients were commenting on not wanting their belongings kept in the "dirty" office. The outdoor courtyard on Derwent ward was covered in moss and littered with cigarette butts.

Each ward held health and safety files that contained up to date control of substances hazardous to health safety data sheets and risk assessments for the environment. However, not all staff had signed to indicate that they had read these assessments. There was no audit in place to ensure all staff adhered to health and safety and control of substances hazardous to health policy and procedures. We reviewed the monitoring of room, fridge, and water temperatures on all wards. Staff did not always carry out the checks as required and did not always report issues. On Derwent ward, staff had recorded daily room temperatures exceeding the recommended 25 degrees celsius on seven occasions but had not reported this. Staff had not recorded the required daily bath and shower temperatures for four weeks.

Greentrees ward had its own activity rooms, while patients at The Humber Centre accessed a shared area known as The Oaks. The Oaks contained various activity rooms and a 'health garage'. Staff escorted patients to The Oaks and supervised them at all times in the activity rooms. Derwent, Ouse and Darley House wards had some health monitoring equipment on the ward but patients primarily used the health garage. The health garage was a clinic room, which was equipped to meet the physical health monitoring needs of patients. Swale, Greentrees, and Ullswater wards had their own clinic rooms, which were fit for purpose and contained the required equipment. The clinic areas on these wards were generally clean and tidy. Patients in South West Lodge utilised the clinic room on Greentrees ward. Emergency equipment and medication was not stored in South West Lodge due to a lack of secure space. Patients had means of summoning assistance and completed a first aid course prior to admission to South West Lodge. Stocks of emergency medicines varied from ward to ward. Four of the wards we visited did not hold the essential stock stated in the trust resuscitation policy, which was due for review in February 2016.This included medicines, which should be immediately available when rapid tranquilisation is used. On Greentrees ward, a member of staff told us they were not aware where emergency medication was kept, and that in the event of a physical health crisis they would call 999.

Handwashing notices were evident throughout the wards and hand gel dispensers were present and in working order. The modern matron reported that results from hand hygiene audits had been lower than they should be and this was an area for improvement. The estates team were responsible for the monitoring and portable appliance testing of equipment in the kitchen areas however, stickers were not always visible and in date on some equipment. The registered general nurse and assistant practitioner had responsibility for the monitoring of medical equipment and would request calibration through the medical physics department when required.

There were six seclusion rooms across the seven wards, one on Derwent ward that was shared with Ouse ward, two on Ullswater, one on Darley House, one on Swale, and one on Greentrees. The seclusion rooms on Swale and Ullswater met the requirements of the Mental Health Act code of practice. They contained no blind spots, had appropriate viewing panels and windows with blinds and were not overlooked from the outside but had plenty of natural daylight. Both rooms had access to bathroom facilities, had a clock that was clear and visible to the patient and a temperature control panel that staff could use. Staff had access to a food hatch and an audio grid for two-way communication. The seclusion room on Darley House was fit for purpose and had an en suite shower and toilet. The seclusion rooms on Swale and Darley House

were clean and ready for use should they be required. The seclusion room on Ullswater was in use at the time of inspection but we were able to see that the room was clean and spoke with the patient.

The seclusion room on Derwent ward had only one hatch meaning that potentially staff would pass food, drink, and bodily fluid through the same place. It was dirty, the hatch had a sticky substance on the surface, and the toilet seat was unclean. This is against infection control principles. It also contained two large plastic boxes filled with clinical supplies. This box could pose a risk to staff and patients should someone be taken into seclusion in restraint and the trust policy stated seclusion rooms should be free of apparent safety hazards. Following feedback from the inspection team, staff closed this seclusion room pending a deep clean on the last day of our visit. Staff had not used the seclusion room on Greentrees ward for five years. There was no blind in place in the window, no hatch and it contained a blind spot. The seclusion room needed cleaning, it appeared dusty, and the floor was not clean. The bathroom was not clean. The ward manager told us that the risks were mitigated because the room was never used; however, they also told us that it was an active seclusion room and could be used in an acute emergency on the ward. We raised this concern with the trust on the day of our visit. Staff told us that the trust had been debating for some time whether to close this room, but had not made a final decision.

Following attendance on the security induction programme, staff were issued with personal alarms. This central system alerted staff across all wards if an alarm was activated and provided the location of the alarm. Staff were designated as respondents each day. The alarm also had a 'man down' function that alerted staff if the person was horizontal in the event of them being unable to call for help. The alarm system could be used as a pager to contact staff and to alert staff to the movement of patients from each ward, such as if one ward was using The Oaks or the shared garden space. There were no nurse call alarms in patient bedrooms. Patients were given the option to carry personal alarms, which would sound if pressed, and alert staff on that ward that they needed assistance. Staff reported that patients tended to decline this option.

Safe staffing

According to data provided by the trust, three of the six wards were above the trust average for vacancy rates of 8.7% between 1st March 2015 and 29th February 2016. Greentrees ward (including South West Lodge) and Swale ward had a total vacancy rate of 19% and Darley House had a total vacancy rate of 10%. Although NHS England reported on the number of advertised vacancies from March 2014 to April 2015, there had been no refresh of this data since. The Kings Fund in December 2015 acknowledged that there was a national data gap on vacancy rates. A report commissioned by NHS Employers in 2015 stated that overall vacancy rate across trusts for registered nurses was calculated at 10%, with regional variances of 7-18%. Swale ward carried the highest vacancy percentage of qualified nurses at 32%, followed by Darley House ward at 18%, Greentrees ward at 17% and Derwent ward at 15%.

The absence rates across all seven wards between 01March 2015 and 29 February 2016 were either higher than or just below the NHS average of 4.7%. Ullswater ward had an absence rate of 8.48%, followed by Greentrees ward including South West Lodge with 7.22%, Swale ward with 6%, Derwent ward with 5.18%, Darley House ward with 4.55% and Ouse ward with 4.05%.

The wards used a rota calculator in order to calculate how many staff they needed to deliver a particular shift pattern. It allowed for any planned absence and could be used to determine what an optimal establishment might be once minimum safer staffing levels had been agreed. Minimum safer staffing levels per ward were as follows;

- Ullswater ward required two qualified and four unqualified staff during the day, with one qualified and three unqualified at night.
- Greentrees ward including South West Lodge required two qualified and three unqualified staff during the day, with one qualified and two unqualified at night.
- Darley House ward required two qualified and two unqualified during the day, with one qualified and two unqualified at night.
- Swale ward required two qualified, four unqualified and two activity workers during the day, with one qualified and three unqualified at night.
- Ouse ward required two qualified, two unqualified and one activity worker during the day, with one qualified and two unqualified at night.

Inadequate

Are services safe?

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

- Derwent ward required two qualified, three unqualified and one activity worker during the day, with one qualified and three unqualified at night.

The Trust submitted data between 01January and 29 February 2016 which indicated that shifts across all wards were often short staffed and covered by bank staff as follows;

- Ullswater ward had 179 shifts covered by bank staff and 27 not filled by bank staff.
- Greentrees ward had 77 shifts covered by bank staff and 24 not filled by bank staff.
- Darley House ward had 140 shifts covered by bank staff and three not filled by bank staff.
- Swale ward had 77 shifts covered by bank staff and three not filled by bank staff.
- Ouse ward had 65 shifts covered by bank staff and 20 not filled by bank staff.
- Derwent ward had 115 shifts covered by bank staff and 31 not filled by bank staff.

The managers used bank staff that were familiar with the service and patients and did not use agency staff. The trust had a flexible working team that could co-ordinate the requests for bank staff in advance, although managers reported they often organised it themselves. Managers felt able to meet staffing requirements if they knew in advance that staff would be absent, but acknowledged getting bank cover short notice was often difficult. Staff on the wards often undertook bank shifts and managers would move staff across the wards depending on patient need and staffing levels. Modern matrons, ward managers, and clinical nurse specialists would provide shift cover if necessary.

Recommendations made by the inspection team in 2014 were that the staffing levels on Ouse and Derwent ward should be kept under constant review to ensure patients did not have their section 17 leave cancelled. On Ullswater ward, patients, carers, and staff told us that section 17 leave and activities were regularly rearranged due to reduced staffing levels. Two patients on Derwent ward, two patients on Ouse ward, and three patients on Greentrees ward reported similar issues. When staff had to choose whether to cancel a patient's section 17 leave or cancel their attendance at training, they reported they chose the latter. Managers only reported cancelled section 17 leave if it was due to staffing shortages. Between 01t October 2015 and 31 March 2016, Darley House ward reported this on three occasions and Greentrees ward on 12 occasions. Staff on Ouse ward reported section 17 leave was frequently rearranged due to staffing problems and that the datix reporting of this did not show the full scale of this issue. If a patient had section 17 leave cancelled on one day but it was re-arranged within that week, then the staff did not have to report that as cancelled leave although it would still affect the patient.

Patients reported being unable to attend routine appointments, such as the opticians and dentist. One patient felt pressured not to access emergency treatment due to lack of staff to escort them. Patient meeting minutes from Swale ward also reflected how external patient appointments were often cancelled due to staff shortages and without the knowledge of the patient. Staff agreed that this was unacceptable and that patients should be made fully aware of details. Patients also identified at times they had to wait for requests to be met when the ward was short staffed. Three out of five staff on Greentrees, five out of ten on Ullswater and all eight staff we spoke with on Ouse ward spoke of staffing shortages. They told us that staff were struggling to cover shifts. The impact appeared to be a lack of time for activities, frequent changes to planned section 17 leave and low levels of attendance at training and supervision for staff.

The previous inspection also recommended that the trust should ensure Ullswater had enough staff when increased observations were required, which had been addressed at the time of this inspection. Staff told us that there was no night-time receptionist at Greentrees ward, which posed problems as the building was isolated from the rest of the wards. This had previously been identified as an issue during a Mental Health Act monitoring visit.

Representatives from all wards discussed staffing at the morning meeting. A review of the minutes between 1 March and 24 April 2016 showed that staffing levels were raised as a concern at 11 out of 34 meetings. If there were continued concerns about staffing levels, managers would raise this at the fortnightly ward business meeting. The meeting had occurred four times in the three months prior to inspection. Minutes from the meeting in January identified that a number of datix were being submitted identifying staff shortages. Discussion took place as to whether these were

actual shortages or staffs perceived idea of being short staffed. Managers noted staff submitted the majority of these when the managers were off duty by the Band 5 nursing staff, who were reporting that something might happen. A review of these datix reports from 1February to 31 March 2016 showed that Darley House ward had submitted five notifications, Derwent ward had submitted three and Swale ward had submitted one. Greentrees ward had submitted 23 datix with 19 pertaining to the lack of receptionist. Ullswater ward had submitted eight, all of which documented the need to cancel section 17 leave due to staffing shortages.

A team of five consultants provided medical input to each ward along with junior doctors. Out of hours medical cover was provided by junior doctors with consultants as second on call. Consultants worked on a rota system covering one weekend in every five. Junior doctors were not resident on site. Staff did not report any concerns about access to medical cover. However, seclusion records indicated that junior doctors did not attend within the required time frames on an evening. Unfortunately, the junior doctors were on study leave at the time of inspection and unavailable for interview. The consultants acted as responsible clinicians and would provide cover for each other's holidays. Managers stated they could access urgent doctors at trust level via the medical staffing department.

Mandatory training for staff included health and safety, moving and handling, fire training and control of substances hazardous to health awareness. The mandatory training compliance rate across all six forensic inpatient and secure wards was 45%. The trust had a minimum compliance target of 75%, with 95% for information governance. Derwent ward had the highest percentage of trained staff with an overall training rate of 56% and Greentrees ward had the lowest aggregated rate at 20%. Information governance had the highest rate of completion with 71%, followed by infection control at 66%. Equality & diversity training had the lowest rate with 14% of staff having completed it. Staff reported that the training data was often incorrect although the managers did acknowledge compliance with mandatory training was not at the required level. The modern matron report for January to March 2016 identified that managers were addressing training requirements during staff supervision sessions and emailing individual training records to staff. They were also putting training lists on staff notice boards to remind staff to attend. Some staff received training in immediate life support although this was not mandatory. National Institute for Health and Care Excellence guidance CG25 states that staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend in an emergency if restrictive interventions might be used. Nineteen staff had attended this training on Derwent ward, ten on Ullswater ward, nine on Swale ward, seven on Greentrees and Darley House wards and only three on Ouse ward.

Assessing and managing risk to patients and staff

We found that across all wards, the use of restraint and seclusion was low for the patient group. Staff explained that they always used de-escalation prior to restraint or seclusion and that this usually worked. The use of de-escalation was not recorded in the seclusion records we reviewed. Patients on Ullswater had positive behavioural support plans in place to support the management of behaviour that could challenge. There were two uses of restraint on two different patients between 1 November 2015 and 31 March 2016, none of which resulted in the use of prone restraint or rapid tranquilisation. In the same period, there were nine uses of seclusion; of these, five occurred on Derwent Ward.

During the inspection, we undertook a review of the use of seclusion. This involved speaking with staff, reviewing the seclusion policy, and reviewing the seclusion documentation for 13 patients. Where seclusion had been used this was not recorded centrally. Staff wrote seclusion and restraint information into a patient's care records. When we asked staff which patients had been recently secluded or restrained they were often unable to tell us. Staff understanding regarding the use of seclusion and segregation across all wards and grades was limited. Some staff told us that they used seclusion rooms in three different ways; 'time-out', 'open door seclusion' and 'closed door seclusion'. Staff reported that 'time out' was used due to a lack of low stimulus rooms on the wards resulting in staff taking patients to seclusion as a form of de-escalation. Staff did not document this as seclusion and therefore we could not see how frequently this occurred. Staff described 'open seclusion' as not allowing the patient to leave but explained that the presentation of the patient did not require them to shut the door. The morning minutes reflected the use of 'open seclusion' and the modern matron stated the trust policy supported this. The policy advocated a graded response to managing behaviour but did not mention the term 'open seclusion'. A patient on

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Greentrees ward told us that seclusion was not used there, but staff would send people to their rooms for 'time-out' if two patients were arguing. Records indicated staff sometimes used seclusion to pre-empt behaviour rather than manage presenting behaviour. One patient record indicated staff took a patient to seclusion to discuss leave arrangements as they predicted a negative response. We found in one record seclusion was commenced when a patient returned from a period of being absent without leave. Staff used it to assess the patient's mental state and ended the seclusion when the doctor arrived after 90 minutes. The Mental Health Act code of practice states seclusion should be commenced: 'where it is immediately necessary for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'. (code of practice paragraph 26.103)

In all records, staff documented 15-minute observations and offered patients food and drink. Staff had not documented exit plans in any of the records when seclusion was commenced. Some records contained a basic plan for seclusion but this did not detail what the patient needed to do or what behaviour or settled period was required to end seclusion. While nursing reviews did take place as per the policy we found that staff frequently deferred decision making regarding ending seclusion until medical reviews were undertaken. This did not meet the least restrictive principle within the code of practice. Patients were often settled for long periods and staff did not terminate seclusion or provide any documented reason for this. Staff were unable to explain this and accepted the notes lacked the rationale for seclusion being commenced in some cases and not ended in others.

In all records, locating chronological information was difficult and in at least four cases seclusion records were incomplete. Records indicated staff did not adhere to the trust policy on seclusion. In eight records, we found a medic had not reviewed patients within the first hour of seclusion. The trust policy detailed the schedule of reviews as follows; 'Maximum one hour - If seclusion not authorised by a psychiatrist, there must be a medical review within one hour of the commencement of seclusion. This should be undertaken by the responsible clinician or 'Duty doctor''. Medical reviews took place on average between two and six hours after the patient was secluded. One record showed the medical review had not occurred until eight hours after the seclusion episode had commenced. This was despite staff documenting the incident that led to seclusion could have been due to a physical condition and the patient being incontinent of faeces. Staff ended this episode of seclusion without discussion with the responsible clinician or duty doctor. The trust policy stated "Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor. This consultation may take place in person or by telephone."

A patient on Ullswater ward had remained in seclusion for over two years. Following an unannounced CQC visit in December 2015, changes were made and the quality of life for this patient had improved. The trust then began to report this patient as being in long-term segregation and provided weekly updates on their progress to the CQC. The patient had an exit plan in place, access to outdoor space and the patient appeared content. Several staff told us that they felt this individual had been incorrectly placed and that the staff team did not have the skills to manage his complex needs. Some staff members told us of their disappointment that an alternate placement had not been located sooner for this individual. The patient was due to be transferred in the coming months. At the time of inspection, this meant that other patients could not use the seclusion room on Ullswater ward. If a patient from Ullswater needed to be secluded, staff would take them to another ward.

Staff understood the supportive engagement policy and used it to manage patients' individual risk. The focus was on engaging with patients rather than observing them and the policy had been developed with input from staff. Staff developed safety plans with patients as oppose to observation plans with the aim being an individualised approach. Patient records evidenced staff increasing or decreasing observation levels as risk levels changed. Nursing staff could increase levels of observation but a decrease in levels needed to be discussed with the multi-disciplinary team. Staff used two recognised risk assessment tools, the galatean risk-screening tool and the historical clinical risk management-20. The galatean risk-screening tool is an evidence-based tool that identifies the individual risks associated with each patient. The historical clinical risk management-20 is a comprehensive set of professional guidelines for the assessment and management of violence risk. The pathways for each ward indicated at which point staff should assess risk. For example, on Ouse ward staff should complete the galatean

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risk-screening tool within three weeks of admission. At that point, staff should commence the historical clinical risk management-20 before reviewing or updating it within eight to twelve weeks of admission. Staff reported that both risk assessments should be reviewed in light of any changes in the patient's presentation and prior to care programme approach reviews. All patients were under a care programme approach, which is a national framework that sets out how mental health services should help people with mental illness and complex needs.

The inspection team in 2014 identified that patients' risk assessments on Ouse ward were not always up to date. A review of seven of the 11 patients' notes on Ouse ward indicated that in six records, staff had not reviewed and updated the risk assessments in line with the care programme approach reviews, or the dates indicating when the assessment had been completed were missing. In four of these records, the care programme approach reviews were also overdue by up to three months. The six records reviewed on Darley House and Swale ward contained up to date risk assessments, as did five records on Derwent ward and seven on Ullswater ward. On Greentrees ward, six of the seven records reviewed contained out of date risk assessments that had last been completed in May or June 2015. A review of internal quarterly case file audits carried out between November 2015 and April 2016 across all wards indicated that on Greentrees ward the historical clinical risk management-20, galatean risk-screening tool and risk and relapse plan were nearly always present but a number were out of date. The same audit showed that on Ouse ward, the documents were not always evident in the files and some of those that were present required updating. Similar issues were present across the other wards, except for Darley House ward where all risk assessments were present and up to date in the last two case file audits.

Feedback from previous inspections and Mental Health Act monitoring visits indicated that blanket restrictions were in place across all wards without an individual assessment of risk and need. Of particular concern were patients on Ullswater being sent to bed at specific times without access to supper. This practice was not in place at the time of inspection and the trust had recently commenced a Section 42 enquiry which was progressing to patient and staff interviews the week after our visit..

The ward security profiles determined whether patients had unsupervised access to certain areas and keys to their bedrooms. However, there was a lack of consistency across the medium secure wards. Some wards based this on an individual assessment of risk and need while on others it remained a blanket restriction. Patients on Derwent, Swale and Ouse wards did not have keys to their bedrooms although they could lock the door once inside. Patients on Ullswater ward had their own bedroom keys where this was safe and appropriate. Patients on Greentrees ward held their own swipe cards to access risk assessed areas of the building. Patients on Greentrees and Ullswater wards had access to hot drinks throughout the day and night. Patients on Derwent ward did not have access to the kitchen or hot drinks without staff supervision. On Swale ward kitchen access was individually risk assessed.

Staff in the forensic service were undertaking a 'restrictive practice review'. Managers and staff were keen to reduce restrictive practice and had begun to have monthly meetings. Staff held a workshop for patients in February to discuss areas of restrictive practice and identify next steps. On Ullswater and Greentrees wards recent changes included open smoking times and patients having control over their own finances. On Swale ward patients now had access to the TV remote as oppose to having to ask staff for it and were able to use the microwave in the patient kitchen. On Darley House, staff used observation and relational security to monitor any patient who had restricted access to certain areas. Managers reported there was some way to go with embedding the use of relational security and removing restrictive practice, but they felt a change in culture was occurring.

Staff across all seven wards supervised patients opening their mail. Inspectors identified this in the last CQC inspection in 2014 but procedures had not changed. Managers informed us that staff would hand patients their mail and stand close by, but not close enough to read the mail. They stated this was to ensure patients did not miss necessary appointments. When asked what staff would do if a patient refused to open their mail, they stated they would try again later and in the meantime would withhold the patient's mail. The trust had a procedure for managing patients' correspondence. The procedure was last reviewed in February 2013 and stated that mail was monitored to prevent the unauthorised passage of contraband and to prevent intimidation of witnesses or distress to others. The procedure identified that 'the recipient will sign to accept

receipt of appropriate packages on the understanding that any postal packet, in the interests of security and safety, must be opened in the presence of the nominated deputy" The supervising deputy will ensure that all packages are opened in full view'.

Section 134 of the Mental Health Act (1983) states that the withholding of mail is only allowed in high security psychiatric hospitals, and only then by agreement of the hospital managers, 'a postal packet addressed to a patient detained under this Act in a hospital at which high security psychiatric services are provided may be withheld from the patient if, in the opinion of the managers of the hospital, it is necessary to do so in the interests of the safety of the patient or for the protection of other persons'. If mail is withheld, the following procedure must be adhered to; 'Where a postal packet or anything contained in it is withheld under subsection (1)(b) or (2) above the managers of the hospital shall within seven days give notice of that fact to the patient and, in the case of a packet withheld under subsection (2) above, to the person (if known) by whom the postal packet was sent; and any such notice shall be given in writing and shall contain a statement of the effect of'. However, Section 134 of the Mental Health Act 1983 does allow outgoing mail to be withheld from delivery within a range of mental health settings where a patient is detained, "a postal packet addressed to any person by a patient detained in a hospital under this Act and delivered by the patient for dispatch may be withheld from the Post Office: (a) if that person has requested that communications addressed to him by the patient should be withheld."

There is no power to withhold the incoming mail of a patient who is detained in a hospital which is not a high security hospital. Paragraph 1.135 of the Mental Health Act Commissions Thirteenth Biennial Report dated 2007-2009 stated: "some medium secure hospital policies stipulate that, whilst it is unlawful to withhold incoming mail from a patient, or to open mail addressed to a patient without the patient's permission, if a staff member has concerns about the possible contents of a particular package or a letter, it is acceptable for the patient to be advised that he or she may only open it in a controlled environment (i.e. nurses' office) in the presence of staff. Once open, the contents maybe treated like any other item of patient property and confiscated if necessary. The Mental Health Act Commissions accepts the need for such arrangements as a last resort, but they should be carefully monitored and reviewed to ensure that they are and continue to be a justified interference with the patient's right to privacy, and must not be used as a blanket measure irrespective of an individual risk assessment". Managers gave the reasons for observing patients opening their mail as wanting to avoid the patient missing key appointments, or in case of families sending restricted items through the post. Managers and staff did not report any issues with contraband on the wards.

Patients returning from unescorted leave were subjected to a 'pat down' search on a random basis which would include checking shopping. Staff undertook bedroom searches randomly on a two weekly basis across all medium secure wards. A patient told us that he did not think staff explained why they were doing this and that he felt he needed the reasons explained more clearly, before searches took place. The reason for these searching procedures was set out in the trust policy as follows: 'In line with the acknowledged risk profiles of this patient group, paragraph 8.31 of the Mental Health Act code of practice allows for the routine and random searching of patients, their accommodation and their belongings. The Best Practice Guidance: specifications for adult medium-secure services standard A43 recognises this practice. It is with this rationale in mind that the application of 'blanket restrictions' (within the meaning of the Mental Health Act code of practice) is considered necessary and proportionate in order to maintain the safety of patients, staff and visitors'. On the low secure wards, staff only conducted room searches if there was a concern about an individual patient and patients had an individual care plan in relation to searching.

Staff understood the procedures for reporting concerns to safeguarding but attendance at mandatory training was lower than required at 69% for safeguarding adults and 65% for safeguarding children, where the trust compliance rate for this training was set at 80%. Staff were able to explain the seven signs of abuse, tell us how they made a safeguarding referral and who the safeguarding lead was. We did see evidence of staff making safeguarding reports and seeking advice where they were unsure of how to proceed. On one ward, staff reported concerns about one patient potentially bullying another. Despite an increase in observation levels and a brief mention of an incident in one of the patients' notes, staff were unclear whether they had reported this to safeguarding and there was no documentation to support whether this had happened.

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The wards had submitted 18 safeguarding referrals in the 12 months prior to inspection. The majority of these were patient on patient assault. Managers reported good relationships with safeguarding teams in the local authority and advised they could speak to them if they were unsure whether to report something or not. Two safeguarding concerns were raised for forensic inpatient/secure wards in the previous 12 months, both of which were closed at the time of inspection.

The Humber Centre had a visitor's policy that identified safe procedures for children visiting the ward. If a person under the age of 18 wished to visit a patient, the social worker would make contact with them and visits would only be arranged in the best interests of the child or young person. A visitor's room was available off the wards and had a selection of toys for children to play with.

Medicines were stored securely and the nurse in charge held the keys. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Medicines requiring refrigeration were stored appropriately and temperatures were monitored daily using data loggers. Staff did not always fully complete medication administration records. We checked 23 records and found that in 11 cases there were gaps, including for some critical medicines. The ward did not have a system in place to monitor or assess whether medication records were completed correctly. The internal monitoring of incidents identified there had been an increase in medication errors with 15 reported between October and December 2015. They were primarily due to issues with errors on medication cards and medication omissions. Staff reported that pharmacists used to attend the multi-disciplinary team but this had changed and they now visited the wards on a weekly basis. Patients on Greentrees ward were an older group and several had ongoing physical health problems. Staff were managing this well and we did not have concerns about pressure sores or ulcers.

Track record on safety

There had been three recorded serious incidents on the forensic and secure inpatient wards between April 2015 and March 2016. Following an incident on Ullswater ward, staff told us that they worked together to keep staff and patients safe. Staff told us that they had received adequate support following this incident, including counselling.

Reporting incidents and learning from when things go wrong

The trust used datix which was an electronic incident reporting system.. All staff were able to tell us how this worked and how they would access it to create an incident. Managers reported datix could be difficult to monitor and that a lack of training meant staff struggled with what to report through datix and what to record in patient notes. The ward manager was required to review the incident report, check patients' notes, speak with staff and then provide a report on the outcome of the investigation. The modern matrons attended an operational risk management group meeting and would feedback any issues to the ward managers. The risk department issued a quarterly risk report to ward managers, which they would then discuss with staff during reflective practice.

Managers acknowledged that they did not always document that they had shared lessons learned with staff following incidents. The wards did not have team meetings with a standing agenda or typed minutes. They had daily reflective practice sessions and handovers where they would discuss incidents and lessons learned with some handwritten notes made. Managers discussed incidents and lessons learned in the monthly specialist care group clinical network meeting. Managers reported that they could share lessons learned with staff during supervision sessions; however, these did not happen as frequently as they should. Staff reported that they discussed incidents during multi-disciplinary team meetings and that they had access to de-brief when needed. Staff felt informed of individual patient risks and there were few incidents across the wards. Staff reported there was no formal learning shared across the services within the trust.

Staff understanding of the duty of candour was varied across ward staff and up to managerial level. Those that understood could give examples of when they had apologised to patients if things had gone wrong. Managers were unable to identify any instances of this in the last six months where a written apology had been issued. They stated that the incident reporting system recorded this information.

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Our findings

Assessment of needs and planning of care

Each ward had a pathway that identified which assessments staff was to carry out at each stage of the patients' journey. Prior to admission, managers would allocate a care co-ordinator who aimed to visit patients wherever possible to aid their transition to the ward. Staff offered families a tour of the unit prior to admission and we saw this happening during the inspection. Staff would undertake a detailed assessment of each patient's risk and need upon admission. The assessment included a physical examination. A registered general nurse and associate practitioner periodically reviewed and monitored the physical health of patients. They undertook electrocardiograms, routine blood tests and an annual physical health and wellbeing review, which included the health improvement profile. Nursing staff undertook clozaril monitoring and held a smoking cessation clinic for patients.

Local general practitioners visited the wards three times per week and district nurses saw patients for the management of longer-term conditions such as diabetes and asthma. Patients from out of the area had difficulty accessing the full range of specialist services if they were not registered with a local GP. One local GP service provided treatment to the homeless population and would register patients of the Humber Centre if they required specialist services. The trust was discussing this issue with the clinical commissioning group in an attempt to reach a resolution.

Medical staff had recommended electro-convulsive therapy for one patient in November 2015 but the patient had not yet received the treatment. The manager explained that discussion about this treatment had commenced almost 12 months earlier. The delay was caused by the logistics of getting the patient to the electro-convulsive therapy suite in another location and the complex presentation of the patient. Despite discussions with the management of actual or potential aggression trainer about how to move the patient the process had still not started.

Staff developed a care plan in conjunction with the patient, which remained static unless the patient's needs changed. Staff used the recovery star to undertake regular reviews of the patient's progress towards identified treatment goals. The recovery star is a tool that measures change and supports recovery by providing a map of a patient's journey to recovery and a way of plotting their progress and planning actions. The recovery star was up to date and personalised in 25 out of 27 care records reviewed.

All forensic and secure inpatient wards operated paper records. The trust was moving to an electronic case note system, Lorenzo, with Darley House being the pilot ward commencing May 2016. Care records were stored securely in locked cupboards in staff offices. The files contained a contents list however; documents were not always stored in the correct section making it difficult to find information at times. Staff acknowledged the paper system was not ideal and hoped the move to an electronic system would make records easier to access. There were also issues with the trust IT systems, such as datix. Managers identified that the way in which it asked for information about incidents, and the way in which staff used the system meant at times that some incidents were reported incorrectly.

Best practice in treatment and care

We reviewed the prescription charts of all patients during the inspection and interviewed all four consultants and the associate medical director. Medical staff stated they adhered to National Institute for Health and Care Excellence guidance when prescribing and administering medication. Staff received information about updates on policies and National Institute for Health and Care Excellence guidance via a generic email. Managers reported they had incorporated National Institute for Health and Care Excellence guidance into the service pathways but felt it could be better embedded in practice.

Staff reported an ongoing issue with access to dental treatment for patients. Patients and carers had also raised this in meetings. Managers had previously attempted to set up dentistry services in the Humber Centre but there had been issues with some of the equipment that would be required. Managers reported taking patients out for appointments could be difficult depending on the required staff numbers for escorts.

The psychology team had not been fully staffed since September 2015 and had a 23.52% vacancy rate. This related to one vacancy in a team of five. The lead psychologist had moved into the post of clinical care director and the vacancy had yet to be filled. A trainee psychologist and two assistant psychologists were due to start in the coming weeks, meaning they would have four psychologists, two assistants and one trainee across the

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seven wards. Psychologists had historically attended all patients multi-disciplinary team meetings on some wards but staffing shortages meant this had reduced. Staff reported that patients did not receive enough psychological input. Psychology staff acknowledged there were outstanding treatment needs for patients but felt they had been delivering some therapies and meeting the urgent needs of patients. Psychological input focussed primarily on pre-engagement work. The atlas programme was a pre-treatment engagement group aimed at individuals who were not yet ready for offence-focused work or more intensive therapeutic work. Staff delivered it either on a one to one basis or in a group format. The objectives were to increase patients' readiness and motivation for further treatment. Staff could use the programme as an introduction to group work and a way to reduce anxiety about undertaking work in a group setting. Some patients were receiving cognitive behavioural therapy and an adapted version of the sex offender treatment programme. The input was offence specific and usually delivered on a one to one basis. Patients and staff told us that they would like to see more psychological therapy available. Some wards had a lack of therapy rooms available, limiting the amount of sessions that staff could deliver. Psychology staff often used the activity or visitor rooms and reported they were not an ideal therapeutic environment.

Psychology staff did not use validated tools to measure outcomes for patients as routine practice. The psychologists inputted to the historical clinical risk management-20 and hoped to introduce the use of psychometric testing in the future. Psychologists led some of the reflective practice sessions for staff. They had also delivered teaching sessions to staff about different psychological therapies. On Swale ward psychology staff had worked with nursing staff using formulation tools to aid understanding of patients' complexities and need. On Greentrees ward, the psychologist was looking at supporting pain management therapy, which the staff felt would be positive for their patient group The psychology team had historically contributed to multi-site studies but were not currently involved in any research. One psychologist planned to submit a research proposal to look at staff attachment profiles however; this was still in the planning stage.

The occupational therapy department comprised four therapists and one technical instructor. The service had recently recruited three assistants who were due to commence employment in May 2016. Occupational therapists used the model of human occupation screening tool to gain a base line assessment of patients' needs and highlight specific interventions that patients may require. They also carried out an assessment of motor and process skills, which provided a measure of the quality of patients' assisted daily living functioning. Psychology, occupational therapy and speech and language staff all reported a desire to be involved in more research and innovation across the service.

Staff completed health of the nation outcomes scales to measure progress towards identified treatment goals for each patient. The results of this assessment would then determine which mental health cluster each patient was assigned to. Staff used the 'my shared pathway' recovery based approach to ensure outcome based collaborative care planning. The 'my shared pathway' work stream is part of the national secure quality, innovation, productivity and prevention programme. It aimed to ensure services focussed on moving patients along a pathway to less expensive community services and ensure the length of stay for patients in secure services was kept to a minimum. Staff completed a malnutrition universal screening tool if they identified a patient as being at risk from nutrition or hydration issues. Clinical staff did not participate in clinical audits.

Skilled staff to deliver care

All wards had some input from a range of professional disciplines including psychologists, occupational therapists, general and mental health nurses, activity workers and a social worker. On Ullswater ward, all qualified nurses were learning disability nurses. Staff had to undertake a five-day induction within eight weeks of commencing employment and were subject to a probationary period. The induction included; ward tours, relational security, 'see, think, act, guidance' and the Quality Network of Forensic Mental Health Services standards for medium secure services. There was a knowledge test at the end of the programme, which highlighted gaps in learning to be addressed through supervision and additional training.

The trust supervision policy stated that managerial and clinical supervision should take place for all clinical staff every four to six weeks. The inspection team in 2014 recommended that all staff on Ouse ward should receive

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regular supervision, as this was not happening. Clinical supervision rates were below 75% on Greentrees (54%) and Ullswater (63%) wards; although the trust data did indicate they were between 88-100% for the remainder of the wards. The ward manager on Ouse ward acknowledged supervision was still not happening as it should. We were shown an email sent to staff in March 2016 acknowledging that some staff had not received supervision in the last 12 months. Managers had placed recording charts on the wall in the staff office to monitor supervision. The sheet for March showed that eight out of 23 staff had received supervision that month. The sheets for January and February 2016 were missing and those from May to December 2015 were either empty, missing or had between one and four staff signatures on them. Staff reported that formal supervision had not been happening and tended to be informal and not documented. Ouse ward submitted a handwritten supervision action plan however; it did not specify how staff were going to improve the rate of supervision. Staff on Greentrees ward told us that supervision took place on an informal basis and was not written down, but felt they could access management support when needed.

Appraisal rates across the forensic and secure inpatient wards varied. On Darley House ward, 100% of staff had been appraised, while only 71% had on Greentrees ward and 73% on Ouse ward. This equated to nine staff on Greentrees ward and seven staff on Ouse ward that had not had a performance and development review in the last 12 months prior to inspection. All doctors at the Humber Centre had been revalidated. Some staff were supported to access additional training with three staff studying at master's level and one undertaking a health training course. Nursing staff on Ullswater specialised in learning disabilities and all staff on the ward had attended a one-day training course on autistic spectrum disorder.

Staff attended daily reflective practice meetings if they chose to. We observed one of these and found they were patient focussed as opposed to a reflection on practice. At each session, staff discussed patients' needs, risk and progress towards recovery. Staff told us that they enjoyed these sessions and found the discussions useful. Psychology staff would run this session once a week and offered informal drop in sessions to staff as needed. There were no formal recorded team meetings. Staff on Greentrees ward identified they would have liked to have team meetings. The manager on Swale Ward had held a team away day and one was planned for Darley House the month after our visit. Managers used these to involve staff in developing the service and to discuss any issues and concerns in a safe environment. Ward managers addressed staff performance using the attendance and performance management policy.

Multi-disciplinary and inter-agency team work

We observed three multi-disciplinary team meetings across the forensic and secure inpatient wards. The multi-disciplinary team would meet each week and review each patient at least monthly. These meetings involved all disciplines of staff and the patient. Staff knew the patient well and the patient felt able to raise concerns and ask questions. Staff ensured the patient understood what had been discussed and involved the patient in reviewing their risk assessment and recovery star. Staff and patients commented on the supportiveness of the multi-disciplinary team and several patients told us that the responsible clinicians were approachable.

We reviewed the shift log records of the twice-daily handovers on some of the wards and observed one evening handover on Derwent Ward. The shift logs included a brief update on each patient and a record of any environmental issues or concerns. During handover, the nurse in charge shared information with the team providing clinical and practical information. The staff discussed individual patient risks, care pathways and physical care and medication needs. The shift logs contained a sufficient level of detail and staff received the correct level of information in the handover to meet the needs of patients. The issues the inspection team had raised that day about the seclusion room being dirty were shared with the night staff.

Ward managers and staff reported good relationships with the local safeguarding teams. Staff regularly attended joint meetings with the safeguarding teams in the local authority and the trust safeguarding department. The wards had a permanent social worker in post, with a vacancy for another. The social worker attended care programme approach reviews and multi-disciplinary team meetings, providing input on family issues, housing and finances, they also undertook liaison work with the patient's local authority and made assessments about children visiting patients. The social worker provided cover on the approved mental health professional rota for Hull local authority,

Are services effective?

Inadequate

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.

undertaking assessments under the Mental Health Act. They also linked with the local multi-agency public protection arrangements team and employment agencies when planning for a patient's discharge.

Psychology staff worked with the local sexual assault referral centre and were involved in the specialist assessment of adults at risk to children in the community. They would provide consultation and full assessments if required, undertaking approximately one or two sessions each month. Swale ward acted as gatekeepers for medium secure services across the county. This involved attending other high and medium secure hospitals to undertake assessments and make decision about the placement of patients.

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

Training in the Mental Health Act was not mandatory for staff at Humber NHS Foundation trust and therefore they could not identify how many people had received training in the Mental Health Act. Training had also not been delivered in the revised code of practice. Ward managers informed us an overview of the Mental Health Act was included in the staff induction and that training was delivered as and when by clinical nurse specialists. Managers did not keep a record of this training. At the time of inspection, all patients appeared to be detained under the appropriate legal authority.

Mental Health Act monitoring visits had taken place across all seven wards between 1 March 2015 and 1March 2016. Twenty three issues had been found across the locations, with the most concerns being in the category of purpose, respect, participation, and least restriction. Greentrees ward and South West Lodge had the most issues in a single visit with six, Derwent and Ouse wards followed with five issues each and Swale ward had the least issues in a single visit with three.

During a previous Mental Health Act monitoring visit it had been identified that Mental Health Act detention records were not accessible on the ward as they should be. The wards had taken copies of all Mental Health Act paperwork and placed them in patient records. At the time of this inspection this remained an issue, as when a new patient file was commenced staff did not always transfer the Mental Health Act documentation from the old file and instead it went to be archived.

The inspection team reviewed nine records across four wards. None of the nine records contained a full set of Mental Health Act paperwork. Examples of issues were missing managers hearing notes in three records, old T2 and T3 forms not marked as cancelled out in four records and most recent renewal of detention missing in two records. Staff use a T2 form when a patient who has capacity agrees to take medication after three months detention. A T3 form is provided by a second opinion appointed doctor when a person who lacks the capacity to consent to medication remains on medication after the first three months detention, or the patient has capacity but does not agree to taken their medication. All leave records had clear conditions detailing all types of leave and staff escort requirements. They were all in date but staff had not cancelled out old forms in four of nine records reviewed.

Independent Mental Health Act advocates attended the wards each week. They provided an open session to patients and were invited to attend multi-disciplinary and care programme approach review meetings. Records showed independent Mental Health Act advocate's had also attended best interest meeting and managers hearings.

A Mental Health Act administrator was not present on the wards and filing of documentation was the responsibility of nursing staff. A lack of training in the Mental Health Act meant that staff did not necessarily know what papers should be present and made filing these papers a low priority. The service was undertaking an audit of T2 and T3 forms however; this was the first audit of Mental Health Act documentation to occur in the previous six months.

Staff practice around providing patients with information on their legal position and rights varied. Staff on Derwent and Ouse wards stated that patients were informed of their rights depending on their presentation as opposed to at set intervals. Staff on Swale ward stated they did not use a section 132 form but instead looked at patient's rights as part of their recovery leave plan and agreed intervals with each patient as to when staff would inform them of their rights. However, the section 132 care plan in patients care records continued to say that staff should give patients their rights weekly or fortnightly. In some cases, patients were receiving their rights every six months. There was no audit of staff compliance with informing patients of their rights.

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Records indicated that decisions to renew, extend, or discharge the detention of individual patients were undertaken with regard to the provision of the Mental Health Act and the principles of the code of practice. However, at a focus group with carers they did not know that as nearest relative they had the right to object to section 3 or to request a discharge.

Good practice in applying the Mental Capacity Act

The inspection team reviewed 32 treatment records of patients, across all seven wards, looking closely at compliance and understanding of the Mental Capacity Act (2005). We reviewed the trust's draft policy for the Mental Capacity Act and deprivation of liberty safeguards, written in February 2016 which contained a brief guide for staff. At the time of inspection, the trust had not yet signed this off.

Training in the Mental Capacity Act had recently been identified as mandatory, and 35% of staff across all six wards had attended this. Only 7% of staff at Greentrees had undertaken this training.

The staff we spoke with were able to demonstrate a basic knowledge of the Mental Capacity Act and gave examples of good practice. Members of the multi-disciplinary team were involved in conducting best interests meetings for those lacking capacity in order to ensure staff made decisions in patient's best interests. However, in two patient files staff had not used the two-stage assessment of capacity, the statutory test for capacity as set out in the Mental Capacity Act code of practice.

The staff we spoke with were unable to tell us who the Mental Capacity Act lead was for the trust, or how to contact this person.

There were no deprivation of liberty safeguards in place, as all patients on the wards were detained under the Mental Health Act (1983).

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During the inspection, we spoke with 26 patients and five carers whose relatives or friends were using the service. We also reviewed feedback left on 19 comment cards and the notes of one patient and one carer focus group held prior to the visit. Of the responses received on comment cards, nine were positive, three were negative, two were mixed, and two were unclear. Comments about staff included that they did a wonderful job, were supportive and helpful, were responsive and that the care was good.

Patients reported that staff were polite, kind and respectful, giving examples such as they knocked on their door before entering their room. Patients felt that staff cared about them and listened to them. We observed positive relationships between staff and patients and saw staff responding to patients' needs quickly. During the multi-disciplinary team meetings, staff tried to empower patients to take ownership of their progress and supported patients to understand their plan of care. Staff encouraged patients to join in activities and events and would organise a take away or buffet to celebrate a patient's birthday.

Staff across all wards had a good understanding of patients' needs. An example of this was a patient who became distressed at changes in staffing and had been allocated a core team of staff to reduce his anxiety levels. The manager on Swale ward had recently introduced a 'getting to know me' book where staff listed their interests, likes and dislikes. This was to enable new admissions to the ward to get to know staff and build positive relationships. They had also introduced 'positive words at handover' to ensure staff said something positive about every patient during handover meetings.

Carers spoke positively about the care the patients received from staff and felt their family members were safe. Two carers explained how the staff brought their family member home for visits and always behaved politely and with respect. We observed two staff members supporting a patient during a visit with family, taking time to talk to the patient and address any anxieties about the visit. Carers reported visits were a positive experience and that staff were always there to ensure they felt safe but respected their privacy.

The involvement of people in the care that they receive

Each ward had an admissions pathway. Prior to admission staff would receive a report indicating the patients level of risk and need. A care co-ordinator would be allocated and would try to undertake a visit to the patient in their current setting. Patient information leaflets were available, although the one for Derwent ward contained out of date information. On the day of admission, the care co-ordinator would be on shift to orient the patient to the ward and introduce them to members of the MDT and their peers. The wards operated a buddy system, which encouraged patients to mentor new admissions and help them settle in.

The trust offered patients the opportunity to provide feedback via the patient experience survey and the friends and family test. On some wards, there were too few respondents to report on the results in order to protect patient anonymity. The survey was most recently conducted on Derwent and Ouse wards in March 2016, with nine patients responding. All patients reported being welcomed to the service on admission and that staff were helpful and friendly. However all patients also reported that they were not able to visit the service prior to admission and did not meet their care co-ordinator in advance. All of the patients on Ouse ward and 66% of those on Derwent ward felt involved in decisions about their care and treatment. When asked if they would recommend the service to friends and family, 50% of respondents on Derwent ward replied positively and 66% on Ouse ward.

Patients had an active role in their multi-disciplinary team reviews. Patients knew who their care co-ordinators were and reported being involved in their care plan. Care plans were personalised and contained the patients' views. Some patients reported staff had offered them copies of their care plans and felt they were able to challenge treatment goals if they did not agree with them. On Ullswater ward, patients had visual diagrams of their own recovery star and pathways to aid understanding.

Each ward held fortnightly community meetings and a representative from all wards was invited to attend the monthly patient involvement and empowerment meeting. We observed one community meeting on Swale ward. The manager had identified that the meetings had become quite negative, so had developed a new agenda and terms of reference in conjunction with the patients. This meeting was attended by 11 out of 15 patients and five staff

Good

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members. Staff encouraged patients to discuss any issues and adopted a proactive and solution focussed approach to addressing these, such as the planned implementation of a 'you said we did' process. The interaction observed between staff and patients was very positive, with staff listening to patients and all patients reporting that they had found the meeting useful.

The patient involvement and empowerment meeting had occurred monthly between September 2015 and February 2016 and involved senior management, ward managers and staff. Staff invited patients from each ward to attend, to discuss matters arising on the wards, and to provide feedback on their care. The trust encouraged patients to be involved in the recruitment of staff, and one patient we spoke to had done this and found it to be a positive experience. The board encouraged departments across the trust to share patient experiences at board level. Staff had facilitated a patient on Swale ward to attend the board meeting and present their own patient journey. A local journalist had noticed this and blogged on social media during the board meeting. The patient felt very positive about this and had enjoyed sharing his story. Patients also attended a regional service user meeting and were due to attend a regional patient involvement conference.

The advocacy service attended the ward weekly. All patients were familiar with service and felt able to access it if needed. Staff encouraged patients to attend the advocacy drop in sessions. Staff also encouraged patients to maintain contact with their families and supported them to use skype. The Humber centre held a carer's group meeting every other month. Thirteen carers had attended the most recent meeting along with the security lead, a nurse and an occupational therapist. Agenda items included information on reducing restrictive practice, service strategies and an opportunity for carers to discuss their experience of visiting the Humber Centre. Five carers told us that they felt involved in care planning and were always invited to meetings. Staff kept them informed of any concerns, were always happy to answer questions and kept in regular contact. However, one carer felt that the regular change of bank staff had a negative effect on the care provided in that they did not know the patients' needs as well as they should. One carer also felt that communication with the ward staff could be difficult at times

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

Each ward had a statement of purpose. Derwent ward operated as an admissions and assessment unit and Ouse ward as a treatment and rehabilitation unit. Staff on Swale ward identified that it could be difficult to meet patient's individual needs as they provided admissions, assessment, treatment, rehabilitation and discharge. The trust had pathways identified between the wards although these could be flexible depending on the patient. For example, one pathway identified that patients from Swale ward moving to South West Lodge would move to Greentrees ward first in order to develop relationships with the staff team who would care for them in the low secure environment. The manager had identified three patients who were almost ready for low secure but did not wish to move to Greentrees first. Instead, staff from Swale ward would work into South West Lodge to support those patients in their transition.

The mean bed occupancy rates between 1 September 2015 and 29 February 2016 varied across the wards. Swale ward carried the highest at 101%, followed by Darley House at 100%, Ouse ward at 98%, Derwent ward at 90%, Greentrees ward at 89%, Ullswater ward at 67% and South West Lodge at 44%. Swale ward had over 100% occupancy due to a patient from Ullswater ward being in long-term segregation on Swale ward for approximately 3 months prior to his transfer to a high secure hospital.

All patients were detained under the Mental Health Act (1983). For those referred to hospital for treatment under section 37 / 41, length of stay was dependent on the type of offence and the ability of the patient to recover and reduce risk to themselves and others. Discharges from this section could only be agreed in conjunction with the secretary of state for justice and had no time limit. Staff completed a 'my future plan' document with patients and the social worker was involved in liaising with community services to prepare for a patient's discharge.

Data provided by the trust indicated that the longest stay patients were on Greentrees ward with an average of 4.3 years. Managers described the use of slow stream rehabilitation with the patient group and therefore they did not expect high or rapid levels of discharge. A large number of patients on this ward had been detained in hospital for the majority of their adult lives. Staff were actively working with some patients to move them to the low secure wards. Some managers identified that it was difficult to see where patients were going due to a lack of outcome measures and monitoring of progress.

The trust reported no delayed discharges and no out of area placements from the forensic and secure inpatient wards between September 2016 and February 2016.

The facilities promote recovery, comfort, dignity and confidentiality

The suitability of facilities varied across the wards. The Humber Centre had a number of shared facilities, such as a patient shop, pool room, and visitor's room. The Oaks contained the health garage, an art therapy room, a wood workshop, a library, a patient kitchen, a sports hall and a social room. The garden area was a shared resource and each ward had access to its own courtyard. Each ward had a patient kitchen and at least two communal areas, one of which contained a television. Derwent and Ouse wards shared a dining room, as did Ullswater and Swale wards. Darley House and Greentrees wards had their own dining area on the ward. Derwent, Ouse and Darley House wards had access to a shared laundry room with identified days and times per ward.

On Swale ward patients had access to a relaxation room and a large welcoming communal area with activities. Greentrees and Ullswater wards had their own activity rooms, which were bright and fit for purpose. The activity rooms on Greentrees ward included a craft room, a woodwork room, a train track, and equipment for activities such as indoor bowling. Staff had access to limited space on Derwent and Ouse wards for one to one work with patients.

The trust provided the Patient Led Assessment Care Environment scores for 2015. The Humber Centre received a score of 99.08% for cleanliness, 93.84% for food, 91.16% for privacy, dignity and wellbeing and 92.33% for condition and maintenance. Greentrees ward incorporating South West Lodge received a score of 99.79% for cleanliness, 92.65% for food, 92.89% for privacy, dignity and wellbeing and 90% for condition and maintenance.

Two patients on Ullswater ward raised concerns about the doors on some of the wards being very loud when they closed and having an impact on their sleeping. The inspection team recommended that this be addressed in 2014 and the trust reported that work had been

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undertaken to rectify it. However, minutes of the patient involvement and empowerment meeting from December 2015 to February 2016 identified this was still a concern. Following the inspection, the estates department planned to review all doors at the Humber Centre that patients had highlighted as slamming and repair or adjust the doors where required.

There were no visiting rooms on any of the wards. All visitors met with patients in the main area of the Humber Centre. The visitor's room had a two-way mirror to allow staff to observe for safety reasons whilst enabling some degree of privacy for patients and their visitors. Staff told us that only solicitor's or professionals were allowed onto the wards but not into patient bedrooms. We spoke with six carers who all told us that they had not seen the ward or the patient's bedroom. Ward managers told us that this was for the security of visitors, staff and patients.

On most of the wards, the telephone was in a shared patient area although staff advised they would support patients to have private calls with ward mobiles or in private rooms away from the ward. During our visit, we noted that most wards had lists of the patient's full names near to exit doors, which acted as a fire register check should staff need to evacuate the ward. These could breach patient confidentiality and given that only first names were used on bedroom doors, it was felt the list could be altered to first names only or initials.

All wards had access to outside space determined by the ward's security prolife. On Derwent ward, staff directly supervised all outside access for fifteen minutes in every hour between 6.30am and midnight. On Greentrees, Ouse and Darley wards outside access was from 7am until 12.00am and staff supervised patients when it was in use, but there was no time limit. On Swale ward, staff supervised access from 7am to midnight. On Ullswater ward, outside access was available until midnight on weekdays and 1.00am at weekends. At South West Lodge, there was open access to outside space at all times.

Patients gave varied feedback about the quality of the food and staff told us that meal times had little flexibility. Each ward had a 30-minute slot for meal times and if patients missed this, they could not have a hot meal. A review of the previous four weeks menu plan showed that patients were given a varied choice of meals with the focus being on healthy eating. At each meal there was a 'light' choice offered of jacket potato, sandwiches or soup. The trust was promoting a healthy lifestyle for patients with fruit and low fat / sugar snacks and desserts offered each day.

All rooms had access to secure storage for patient's possessions. All bedroom doors had the facility to open outwards in the event of a patient barricading themselves in their room.

On Darley House ward, patients had free access to the kitchen other than during meal times. Patients self-medicated and kept their medicines in a safe in their rooms. Patients had no restrictions placed on them in terms of how much money they could keep on their person and were able to have access to a basic mobile phone on the ward. Staff provided patients on other wards access to a restricted mobile phone when on unescorted leave.

Patients at South West Lodge moved to this low secure unit prior to their discharge to the community. There was no staff team based there, but the staff from Greentrees visited six times per day. Two of these visits included an environmental check and staff locked sharps away at night. Patients signed in and out of South West Lodge according to their leave plan. Patients self-medicated and self-catered according to individual risk assessments. Patients living at South West Lodge had access to their own keys and their own garden without restriction. They also completed their own cleaning and laundry.

Staff encouraged patients to join in activities and events. On Darley House ward staff would take patients fishing and had planned a trip to the races the following month. On Greentrees ward staff encouraged patients to purchase items of interest to them and to develop hobbies to aid their recovery. On Swale ward they made use of the social room to have movie nights with popcorn. The wards employed an art therapist and patients spoke very positively about their involvement in art therapy. Activities were planned across all wards over seven days including breakfast groups, cooking, walking groups, craft groups, group therapy sessions, gym sessions, sports groups and gardening groups. Staff reported that cooking was the main activity. The service had developed an inclusion football league five years earlier that now included several teams made up of trust staff and service users. Patients reported enjoying the football and staff felt it had helped to break down barriers across different services. The occupational therapists were leading on a piece of work called an activity

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hub, which was due to commence in May 2016. This was an initiative that involved utilising occupational therapsits and activity staff across different areas according to their skill set, in order to share resources and meet patient needs. The initiative would form part of a larger piece of work that centred on the development of a recovery college approach within the Humber Centre. Staff hoped the first prospectus would be available from September 2016 and would involve courses on 'do it yourself' skills, first aid and food hygiene.

Although some activities were happening and further plans were in place, 14 staff and nine patients reported that there was a lack of activity on the wards. Facilities were there but staff were often unavailable to support these activities due to staff shortages. On Derwent ward there was an activities cupboard containing games and craft items, which staff used when they could. On Ullswater ward we saw that an activity plan was about to start on the week of our visit. One patient commented that lack of activity and structure made him feel bored, stressed, and had an impact on his mental health.

Staff felt it was not always clear how activities were linked to recovery goals. They reported a lack of connection between activity workers and the occupational therapy team. Patients had little English and mathematics input as there was no education tutor. Occupational therapy staff felt the department was small. They identified there were not enough activities on the wards and that staffing levels could not meet the demands of the service. The service did not monitor if activities were cancelled, or the number of patients engaged in meaningful activity at any particular time of the day. There was a vacancy on Greentrees ward for an activity worker which had influenced the level of activity offered to patients. Staff told us that the ward was quiet during our visit as most patients retired to bed in the afternoon.

Meeting the needs of all people who use the service

The service employed two part time speech and language therapists and a part time speech and language assistant. The therapists spent the majority of their time working with patients on Ullswater ward regarding communication, capacity, consent and patient pathways. Staff felt that this therapy was very positive for the patient group and fed into the patient's treatment plan in MDT meetings.

A building accessibility audit conducted in 2013 indicated that the building and wards were accessible by patients with a disability and that a disabled access bathroom was available. There were no specifically designed accessible bedrooms although all bedrooms were deemed accessible to those with a disability.

The wards displayed information on patients' rights and how to complain to the patient advice and liaison service, the CQC and the commissioners. The trust had developed an interpretation and translation policy in February 2016. Staff could access leaflets in other languages and one patient was regularly accessing an interpreter because English was not his first language. The kitchen could cater to meet the dietary requirements of religious and ethnic groups.

The Humber Centre had a multi-faith room containing religious texts and items. A priest was available to meet with patients each week on a one to one or group basis. Staff told us that if this arrangement was not sufficient, patients could ask for support to meet their cultural or religious needs and this would be considered in their initial assessment. Staff gave an example of a patient who was pagan and staff had sought reading materials for him.

Ullswater was a learning disability specific ward and we found that it catered well for the needs of the patient group. For example, patients and staff used a Velcro signing in board, which was easily readable and accessible to patients. The ward contained brightly coloured signage explaining the patient journey at an appropriate level.

Listening to and learning from concerns and complaints

Patients reported they knew how to complain and would feel comfortable doing so. Responses based on the friends and family test and patient experience survey in March 2016 indicated all three respondents from Ouse ward and 83% of those from Derwent ward had been given information on how to complain if they were unhappy with the care they received,

The forensic and secure inpatient wards had received 11 formal complaints in the 12 months prior to inspection. Seven related to Swale ward and four to Ouse ward. Three of the complaints from Ouse ward were about restrictions on things such as snacks, takeaways and smoking when the trust began promoting a healthier lifestyle for patients. The trust upheld these complaints. One complaint on Ouse

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ward was not upheld and related to a patient's understanding of their care plan. Three of the complaints on Swale ward related to errors regarding physical healthcare treatment, and all were upheld. Three complaints related to communication errors by the ward staff and of these, two were partially upheld, and one was fully upheld. A complaint relating to a staff response to an incident was not upheld.

Staff told us that they would feel confident to complain about poor practice to their direct line managers and that they would not feel bullied or intimidated. Staff had dedicated time with the psychology staff each week to reflect on their practice and to discuss any concerns. Staff used multi-disciplinary team meetings to discuss patient incidents or complaints.

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 trust vision was to be caring, compassionate and committed. The trust values were; putting the needs of others first, acting with compassion and care at all times, continuously seeking improvement, aspiring to excellence, and valuing each other and teamwork. The values were on display throughout the wards. Staff up to managerial level did not know the trust's vision and values. Staff interaction with patients was compassionate and team working was strong on each ward. Each ward had a statement of purpose that incorporated the vision and values and identified objectives for the service. These varied across all seven wards and examples included promoting patient and carer involvement, evidencing that changes had taken place, working with patients to enable them to move on and working collaboratively with patients to prevent deterioration in their mental health.

Staff provided a mixed response when asked if the senior executive team had visited the wards. Some said they had never seen them and felt a disconnect to senior management. Some stated that senior managers had visited the wards and spoken to patients and one reported that they had attended the team away day on Swale ward. Members of the senior management team acknowledged that the connection between themselves and front line staff was not as good as they would like, but felt that staff would feel safe in the knowledge the managers were there. Ward managers felt supported by the service manager, associate director and clinical care director.

Good governance

Across all wards, there was a lack of oversight and action taken when issues were identified. Managers were not proactive in ensuring systems were effective. Staff had not received appropriate levels of mandatory training and not all staff were receiving regular supervision and appraisals. A submitted action plan from November 2015 contained little information on how they would improve this and it remained an issue five months later. Vacancy rates and absence rates were above both trust and national averages, shifts were frequently short staffed and section 17 leave and activities were frequently cancelled. Staff reported incidents via datix however managers reported staff understanding of the system was limited. Wards did not have team meetings and therefore did not clearly document lessons learned from incidents with front line staff. Mental Health Act documentation was not in order and risk assessments were not always up to date.

This lack of oversight was in part due to a lack of audit programme. Senior managers acknowledged the audit programme was not where they would want it to be and said it needed to be 'kick started'. Staff conducted 'defensible documentation' audits monthly and undertook quarterly care file audits to improve recording and monitor the completion of tools such as the galatean risk-screening tool and historical clinical risk management-20. A review of these in the six months prior to inspection showed a number of issues were frequently identified with no evidence of action taken to rectify this. There was limited audit of Mental Health Act documentation on the wards and ward managers were unaware of whether the Mental Health Act Administrator conducted any audits. Front line staff did not participate in clinical audits. The only clinical audits conducted in the six months prior to inspection were two medication audits involving pharmacists and doctors.

The manager on Darley House ward had developed procedures to monitor staff attendance levels at supervision and training but this was not consistent across the wards. The manager on Swale ward identified it was difficult to see where patients were on their treatment journey. In response, she had recently started to monitor outcomes and had set up pathway meetings for patients. These meetings reviewed all patients with imminent or on-going plans for movement along their treatment pathway. Outcome monitoring was conducted on an individual basis through multi-disciplinary team meetings and care programme approach reviews.

The management team had completed an action plan in response to the inspection in 2014 and identified all five issues had been resolved. During this inspection it was apparent four issues remained and were therefore subsequent breaches of the regulated activities regulations 2014.

The Humber Centre had taken part in the self-review and peer review in September 2015 of the quality network for forensic mental health services. This adopted a multi-disciplinary approach to quality improvement by sharing best practice and enabling services to benchmark against similar services. Services worked through an annual process of self and peer review against set standards and

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complied an action plan. The action plan for the Humber Centre indicated that the low secure services had two unmet criteria, eleven partly met criteria, and two met criteria with suggested actions. The medium secure services had five unmet criteria, fifteen partly met criteria and nine met criteria with suggested actions. The results of this review process did not appear to have been shared with all staff and outstanding actions remained. An example of an outstanding action for an unmet criterion would be that patients were not receiving draft reports one week prior to their care programme approach reviews and reviews were not always happening every three months. The action plan stated that the wards would identify a care programme approach lead and at the time of inspection, one of the managers had been given this task, although some other managers were unaware of this. Records showed and staff reported that care programme approach reviews were still not happening every three months despite this being an issued identified six months previously.

The trust used key performance indicators to measure their performance in areas such as clinical supervision for staff, care programme approach reviews, risk assessment reviews, safeguarding training compliance, outcome plans for patients and delayed discharges. Across all wards, the required targets for clinical supervision and attendance at safeguarding training were unmet. However, all wards were meeting targets for follow up care programme approach reviews on discharge. Ward managers told us that they used these indicators, alongside commissioning for quality and innovation targets to plan service delivery effectively. The performance department produced key performance indicator reports on a monthly basis and individual unit managers addressed any outstanding issues. Managers shared any unmet targets or areas of concern with staff through reflective handovers. The ward managers received a quarterly performance report and met with the performance lead to review the data. The performance lead also attended the ward business meeting once a month.

Ward managers felt they did not have sufficient administrative support and that the completion of administrative tasks took time away from nurses to provide care and treatment. Managers had made a plan to recruit ward clerks in order to ensure protected nursing time for patients.

The ward managers told us that the trust was reviewing the risk register because the services were not separated and the information was complicated and not regularly updated. If ward managers wished to submit an item to the risk register, they would raise their concerns with the modern matron. The modern matron would then raise this at the forensic service business meeting. At the time of inspection, two items on the risk register related to the forensic and secure inpatient services. One pertained to the potential risk of violence and aggression from patients and one to potential contracting issues in the coming year.

Leadership, morale and staff engagement

Humber NHS Foundation Trust took part in the 2015 NHS national staff survey. Results were varied and were not broken down to core service level. The culture of care barometer in March 2016 for the Humber Centre showed that the issues of greatest concern were staff vacancies and communication. Staff felt staff shortages impacted on service delivery, that gaps in staffing increased the workload and pressure therefore reducing the level of overall care and that there was a need for greater communication from the bottom to the top. The health and safety executive stress management standards had been conducted on all wards with varying results. Areas identified for improvement included staff being able to take regular breaks, staff understanding how their work fits into the overall aims of the organisation and strained relationship within the workplace.

In addition to talking individually with staff, we ran focus groups for nurses, doctors, junior doctors, administrative and support staff. Staff talked of good levels of morale and of enjoyment at coming to work. Staff felt safe at work and well supported by their colleagues. However they talked of issues with low staffing levels affecting their stress levels and of a disconnect with senior management. One staff group felt the service needed to place a greater focus on staff well-being. They raised concerns that staff were burning out and did not have time to focus on training and development. Staff knew the whistleblowing process and ward managers told us that they encouraged staff to speak out and report issues. Six staff reported they had raised concerns without fear of victimisation and managers had supported them in doing so.

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.

Commitment to quality improvement and innovation

The Humber Centre was involved in the development of a recovery college model, which was a collaborative approach across staff groups and patients to focus on tools and training to aid better recovery.

The wards were reporting on four commissioning for quality and innovation targets; cardio metabolic assessment for patients with schizophrenia; collaborative risk assessment; smoking cessation and supporting carer involvement. The projection for January to March 2016 indicated the services were on track to meet their targets.

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 The trust did not ensure the care and treatment of patients always met their needs. Staff did not provide patients with sufficient access to meaningful activities to aid their recovery.

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 Staff did not always regularly review and update risk assessments relating to the health, safety and welfare of patients. This was a breach of Regulation 12 (a)

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises were not clean, suitable for the intended purpose or well maintained. The environment on Derwent ward, Ouse ward, Greentrees ward, and Darley House ward was in a poor state of repair. The seclusion room on Derwent ward was dirty. The shower rooms on Derwent and Ouse wards contained rust and lacked ventilation. This was a breach of Regulation 15 (1) (a) (c) (e)

This section is primarily information for the provider

Requirement notices

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 The trust did not have effective governance in place, including the assurance and auditing of systems and processes, to asses, monitor and drive improvement in the quality and safety of the services provided. Staff did not maintain an accurate, complete and contemporaneous record in respect of each patient. Staff did not always document when they had administered medication to patients. Mental Health Act documentation was not always up to date or fit for purpose. This was a breach of Regulation 17 (1) (2) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they could meet people's care and treatment needs. The wards were often short staffed and vacancy levels were high. Staff and patients reported that staffing shortages limited patients' access to Section 17 leave. Staff did not receive appropriate training and supervision as was necessary to enable them to carry out the duties they were employed to perform. Staff attendance at mandatory training was below the trust requirements. Staff were not receiving regular clinical and managerial supervision in line with the trust policy. This was a breach of Regulation 18 (1) (2) (a)