The Spinney

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The Spinney as good because:

- wards were clean and generally well maintained, with systems to allow effective observation of patients
- staff checked emergency equipment regularly to ensure it worked properly
- staff completed and reviewed risk management plans
- staffing levels were safe and staff received appropriate mandatory training
- staff completed care plans which were up to date and reviewed regularly
- patients had good access to psychological therapies
- staff had good opportunities for training and development
- patient involvement in their own care was excellent
- patients were highly involved in shaping the service – for example, interviewing staff
- patients could engage in a wide range of meaningful activities
- staff and patients had established excellent community links and vocational placements
- patients were engaged in meaningful employment and gaining real work skills
- carers provision was excellent and innovative
- patients and staff knew the complaints procedure and there was effective ward-based recording and resolution
- staff understood and demonstrated the values of the organisation
- staff felt supported and valued
- there was a clear governance structure with effective management across the service
- ward and senior managers provided effective leadership
- staff were committed to improving quality.

However:

- staff did not always complete a risk assessment of patients at admission
- patients were subject to some blanket restrictions on their freedom, which might be unnecessarily restrictive
- staff did not always monitor the use of high dose antipsychotic medication in required cases
- physical health documentation, including records of examination, was difficult to find in the records
- managers were not supervising the work performance of nursing staff as defined in the hospital policy and were not ensuring that staff meetings took place regularly
- patients complained about waiting times for a specific psychological programme
- we were concerned about the use of observations lounges in some wards and documentation of this
- staff recorded some instances of seclusion wrongly as long-term segregation
- staff's knowledge of the Mental Capacity Act was inconsistent across different wards
- staff identified difficulties in procedures around maintenance requests.

Summary of findings

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Good

The Spinney

Services we looked at

Forensic inpatient/secure wards

Summary of this inspection

Background to The Spinney

The Spinney independent hospital is part of the Partnerships in Care group. It is registered to provide the following regulated activities:

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

The hospital provides medium secure, low secure and psychiatric intensive care services. The service is for male patients. It has 90 beds split over seven wards.

Shevington ward

Core service provided: Forensic in-patient/secure wards

Capacity: 14 beds – medium secure

Hesketh ward

Core service provided: Forensic in-patient/secure wards

Capacity: 15 beds – medium secure

Rivington ward

Core service provided: Forensic in-patient/secure wards

Capacity: 16 beds – medium secure

Pennington ward

Core service provided: Forensic in-patient/secure wards

Capacity: 10 beds – medium secure

Lever ward

Core service provided: Forensic in-patient/secure wards

Capacity: 15 beds – low secure

Hindsford ward

Core service provided: Forensic in-patient/secure wards

Capacity: 10 beds – low secure

Hulton ward

Core service provided: Psychiatric Intensive Care unit (PICU)

Capacity: 10 beds

During the inspection, there were 90 patients at the hospital. All patients were detained under sections of the Mental Health Act. The length of stay varied considerably by ward, with some patients having been admitted for long-term secure care.

The hospital had a registered manager and controlled drugs accountable officer in place at the time of inspection.

We have inspected The Spinney three times since 2010. At the last inspection in December 2013, The Spinney was meeting essential standards, now known as fundamental standards.

We have reported on forensic/inpatient secure wards and the Psychiatric Intensive Care Unit (PICU) together within this report.

Our inspection team

Team leader: Andrea Tipping, CQC Inspector

The team comprised three inspectors, an inspection manager, two consultant psychiatrists, three psychiatric nurses, a governance advisor, a Mental Health Act reviewer and two specialist pharmacists. The team also included two experts by experience (someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer).

Summary of this inspection

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information Including specialist commissioners.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 39 patients using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 66 other staff members; including doctors, nurses, social workers, psychologists, occupational therapists, heads of non-clinical departments and housekeepers
- interviewed the hospital director
- conducted focus groups with medical staff, occupational therapy staff, maintenance and administrative staff
- attended and observed one handover meeting, two care programme approach (CPA) reviews and one multidisciplinary meeting
- attended a patients' council presentation
- met with members of the local community and employment projects used by patients
- attended a community skills session based in a local resource centre
- carried out Mental Health Act monitoring visits on Shevington and Hesketh wards
- collected feedback from 27 patients/staff using comment cards
- looked at 30 treatment records including risk assessments and care plans
- carried out specific checks of the medication management on all wards
- reviewed five seclusion records and ward seclusion registers
- reviewed the care records of two patients subject to long-term segregation
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 39 patients across all seven wards, 35 on the forensic inpatient/secure wards and four on Hulton ward, the psychiatric intensive care ward. We also collected 27 comment cards.

On the low secure wards, patients spoke positively about their involvement in their care and felt staff were polite, caring and supportive. They reported good access to nursing and psychology input and a wide range of activities available. Several patients said they were involved in the Mission Fit programme, a 13 week programme focussing on improving diet and increasing physical fitness, and were enjoying this. Patients valued opportunities for real work opportunities. Patients said community meetings were effective in raising issues. Patients were pleased with access to mobile phones and the internet. Some patients said they would like more dialogue about care pathways and timescales for discharge.

Summary of this inspection

On the medium secure wards, patients told us staff were good and that they felt safe. Several patients mentioned staff skills in talking to them when distressed and their verbal de-escalation skills. There was a good range of activities available. Four patients felt their recovery was delayed because they were waiting for therapies to start, particularly the Life Minus Violence programme.

On the psychiatric intensive care ward, patients told us they felt safe. They described good therapeutic relationships with staff. Patients made positive comments about access to activities. Patients completed discharge surveys on Hulton ward to provide feedback about the service. We reviewed six of these surveys. All were positive about the service, although two patients suggested they would have liked more occupational therapy input.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- staff did not always complete a risk assessment of patients at admission
- patients were subject to some blanket restrictions on their freedom, which might be unnecessarily restrictive
- we were concerned about the use of observation lounges on one ward and documentation of this
- staff recorded some instances of seclusion wrongly as long-term segregation
- staff did not always monitor the use of high dose antipsychotic medication in required cases
- staff did not ensure timely review of medication, including duration of treatment and dose required.

However:

- wards were clean and generally well maintained, with systems to allow effective observation of patients.
- staff checked emergency equipment regularly to ensure it worked properly and was accessible
- staffing levels were safe and well monitored
- staff received appropriate mandatory training
- there were low levels of restraint and where restraint had been used this was clinically indicated and documented clearly.

Are services effective?

Good

We rated effective as good because:

- staff completed care plans which were up to date and reviewed regularly
- patients had good access to psychological therapies
- staff had good opportunities for training and development
- there were comprehensive multidisciplinary teams including medical staff, nursing staff, social workers, psychology staff and occupational therapists.
- Staff received an annual appraisal of their work performance.
- Staff received a comprehensive induction prior to starting work in the hospital
- There was effective local community liaison and partnership working evident.

However:

Summary of this inspection

- physical health documentation, including records of examination, was difficult to find in the records
- managers were not supervising the work performance of nursing staff as defined in the hospital policy
- managers were not ensuring that staff meetings took place regularly
- patients complained about waiting times for a specific psychological programme
- staff's knowledge of the Mental Capacity Act was inconsistent across different wards.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- patients gave consistently positive feedback about the service
- there were caring, respectful interactions observed across the service
- patient involvement in their own care was evident across all aspects of care
- there was imaginative, personalised activity planning and truly individualised care
- there were innovative opportunities for education and employment
- regular community meetings were held and actions taken from these
- patient surveys were regularly undertaken and actions taken from these
- patients were involved in shaping the service, for example, interviewing staff
- patient involvement was valued and encouraged at all levels, from ward level to the hospital governance committee.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- There were clear referral pathways into service and within the services
- facilities were good, including visiting areas
- carers provision was excellent and there was an emphasis on involving carers in training and hospital governance.
- patients could engage in meaningful activities
- staff and patients had established community links and vocational placements
- patients were engaged in meaningful employment and gaining real work skills
- there was an emphasis on meaningful employment and gaining real work skills

Summary of this inspection

- patients and staff knew the complaints procedure and there was effective ward-based recording and resolution.

However:

- Patients could not self-medicate on one ward due to a lack of suitable storage.

Are services well-led?

Good

We rated well led as good because:

- staff understood and demonstrated the values of the organisation
- staff felt supported and valued
- there was a clear governance structure with effective management across the service
- there was an emphasis on developing staff skills
- ward and senior managers provided effective leadership
- staff were committed to improving quality
- the service was involved in national quality outcomes monitoring.

However:

- supervision was recorded as taking place but records could not always be found to substantiate this
- staff identified difficulties in procedures around maintenance requests.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All patients at the time of inspection were detained under the Mental Health Act 1983. We found good adherence to the Mental Health Act and code of practice overall at this location.

A Mental Health Act reviewer completed two monitoring visits during this inspection on Shevington ward and Hesketh ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found knowledge of the Mental Capacity Act to be variable across the service. The provider was addressing this ensuring training was available to staff. We saw examples of capacity assessments relating to specific decisions in use.

There is no use of deprivation of liberty safeguards at this service.

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

All the wards visited were spacious, with communal spaces and smaller more private areas for patients. The layout of some of the wards made it difficult to observe patients in all areas. Staff managed this by having staff observing bedroom corridors. Some wards on the medium and low secure services also had CCTV monitoring within the corridors. Convex mirrors enabled staff to observe blind spots within the environment, for example, in kitchen areas on Shevington and Hesketh ward. Observation on Hulton ward was good, with a large open plan layout.

There was good overall management of ligature risks across the wards, with ligature risk audits completed and reviewed monthly. Staff had a good awareness of the location and management of these within their own ward areas. Ligature cutters were accessible on all wards and all staff knew how to access these in an emergency.

Staff checked emergency equipment daily to ensure it was fit for purpose. Emergency equipment was stored in an area where it was readily accessible to staff. There were clear signs indicating to staff where the nearest defibrillators were.

The seclusion rooms on all wards were inspected. The hospital was in the process of upgrading the seclusion rooms and on Pennington ward this was nearing completion. Those in use had windows providing natural light and external controls for light and ventilation. Staff and patients could communicate using intercom systems. There were clocks which were clear to read from within the room and some facilities had access to televisions or music. None of the seclusion rooms within the forensic wards had integrated toilet facilities meaning that disturbed patients may have to use disposable urine bottles or bedpans if it was felt too high risk to enable use of the separate bathroom. This had been addressed in the new seclusion room and on the PICU ward where the seclusion rooms had integrated bathrooms.

On Lever and Hulton wards there were strong clothing suits available which could be used for patients in seclusion if they were at risk of tying ligatures. Both suits were damaged and staff assured us they would not be used at any future point until they had been replaced.

The wards were clean and tidy. Cleaning audits showed the housekeepers checked cleanliness of the wards daily and identified any areas needing additional attention. Patients reported wards being clean and cared for. Housekeepers clearly took pride in maintaining the environment. Ward staff completed regular health and safety audits either daily or weekly dependent upon what was being monitored.

Staff followed Infection control procedures. An infection prevention champion on each ward attended the service infection prevention meetings and ensured that staff on each of the teams were updated on any specific infection prevention issues. However, on Pennington ward, clinical waste bags were accruing in a storage box in the clinic room and it was not clear how long they had been there.

A security nurse was allocated each shift on every ward and was in charge of monitoring accessibility of high-risk items (e.g. razors), environmental checks and observation checks on a set basis depending on the security needs of the ward. They also monitored staff and patients entering and leaving

the ward. Each ward had a designated security champion who was responsible for offering advice and support to other staff and attending regular security meetings and disseminating information from these. Staff had a good awareness of relational security and the importance of reporting any concerns promptly. New staff were not given keys until they had completed the security induction.

Staff carried personal alarms which could be used to alert staff on other wards of emergency situations. Staff were allocated on each ward to respond to incidents on other wards if required. On some wards, there were wall mounted alarm bells, but these were not connected to an alarm system, which could be confusing for patients or visitors. Staff used two way radios when escorting patients in the hospital grounds. Communications over the radios were suitably anonymous, given that this is not a secure form of communication.

Safe staffing

The total number of whole time equivalent (WTE) substantive staff for the hospital as at 31 August 2015 was 331. The total number of staff leaving in the previous 12 months was 73. The staff turnover in that time was 21.5%.

The staff vacancy rate was 26% on 31 August 2015. Some vacancies were due to staff promotion and service expansion. At the time of inspection, staff had been recruited to all vacant qualified and unqualified nurse posts and were awaiting final start dates.

Each ward had a safe minimum staffing number per shift. Ward managers had flexibility to increase this to cover leave or observation levels.

Hulton ward adhered to safe staffing guidance as recommended by the national association of psychiatric intensive care and low secure units (NAPICU) standards. This is a minimum of six staff per day and four staff at night for a ten bed service.

Medium secure wards operated an establishment staffing level of six staff on days and four staff on nights. On the low secure wards, Lever ward had a staffing level of six staff on day shifts and four at night, whereas Hindsford ward had four staff on days and two staff at night. There were two qualified nurses during the day and one qualified nurse at night across all the wards. Staffing establishments were good in terms of ratios of staff to patients.

Staff shortages were covered in the first instance by offering overtime to permanent staff or using a well-established nurse bank. Managers told us it was rare to use agency staff and in this case the provider tried to ensure consistency of requesting staff who had worked in the service before and exclusive use of one nursing agency. We reviewed staffing rotas for the period of six weeks prior to this inspection and saw that there were no shifts unfilled. The data we received for a six-month period prior to this also showed there had been no shifts unfilled. During Monday to Friday between 9am and 5pm there was a resource manager based within the service who undertook co-ordinating shifts for nurse bank and agency on behalf of the ward managers.

Staff sickness levels were low at 2.7%. Nursing staff sickness/absence figures over the year were below 5% except for one month, April 2015, with a figure of 5.6%.

Senior managers met on a daily basis to ensure safe staffing levels were in place. There was an extended handover meeting twice per week to look at longer term planning including weekends. Ward managers reported being able to adjust staffing levels as needed within their own clinical areas. Extra staff could be booked for specific activities or needs. There was evidence of this during the inspection with several community activities planned, including trips to the Illuminations in Blackpool during the evening.

There were sufficient medical staff during the day to respond to an emergency. A member of the medical team undertook reviews on Hulton Ward daily. There was a separate on call rota for Hulton Ward reflecting the nature of the service in terms of admissions out of office hours. A doctor can attend Hulton ward within 30 minutes of being contacted. The on call medical rota for psychiatric emergencies/seclusion reviews in the forensic wards had doctors on a rota covering the Spinney and another hospital. In the evenings and at weekends, there was also cover available by a local out of hours GP service for physical health complaints.

Staff received appropriate mandatory training. Levels of completed mandatory training such as fire safety and infection control were above 85%. The only exception was that 35% of staff were overdue for immediate life support (ILS) training, at the time of inspection. This was improving followed by problems earlier in the year with the external training provider. Courses had been cancelled by the external training provider due to their own staffing issues. A

new contractor had been rapidly appointed and there was an action plan in place to ensure all staff received the training as soon as possible. There was always a number of ILS trained staff on duty across the service.

Staff had recently received Mental Capacity Act training. On Hulton ward, staff had received additional Mental Health Act training to enable them to check detention papers. This was important due to the high number of admissions.

The provider had introduced an e-learning system (iLearn). Staff were able to access the system remotely from home if they preferred and could claim time owed for completion of elearning in their own time. Staff were able to use laptops on site off the main ward areas to facilitate access to mandatory and other training. It was anticipated it would be easier for staff to remain up to date with required training with ilearn in place.

Staff completed management of violence and aggression (MVA) training on a yearly basis. Staff spoke positively of the emphasis on de-escalation skills and body language, feeling this equipped them with confidence in dealing with difficult situations.

Assessing and managing risks to patients and staff

The risk assessments for ten patients were examined. Risk assessments were completed prior to the first care review three months following admission. The historical clinical risk management-20 (HCR-20) and short-term assessment of risk and treatability (START) risk assessment tools were completed. However, in some of these records, we found no formal risk assessment completed before this time or at admission. This means that staff were not always aware of an individual's specific risks or how to manage these. We were told that this information was within the pre-admission assessment but this section was not completed in some of the records examined and in two cases the pre-admission assessment could not be found. Escort risk assessments were completed, but they focussed solely on risks related to leave.

HCR-20 risk assessments were in place at the first review following admission. These were thoroughly completed and there was evidence at inspection that these were being regularly reviewed.

Staff were implementing strategies in line with the Department of Health Positive and Proactive Care guidance. This included de-escalation and support care planning, reducing restrictive interventions and increasing awareness of the dangers of these, completing post incident reviews and debriefs and a focus on recovery. There were blanket restrictions in place on all the wards visited. These often related to the security of the environment and safety of the patients, for example, in relation to lighters and matches or cutlery. These are necessary in a secure hospital and were being applied as per the company policies. Most wards had rules restricting room access during the day, but on several wards these appeared unduly restrictive, for example, being unable to access bedrooms for two hours whilst cutlery was in use for a meal.

On the two low secure areas, patients had access to mobile phones subject to risk assessment and a care plan. Care plans included allowing staff to screen the phones when handed back after use. This arrangement was in place for all patients who had phones. This would appear to be an unreasonable blanket restriction and potential infringement of privacy as it did not appear to be specifically individually risk assessed.

There was a positive risk taking ethos evident on many of the wards. On Shevington ward (the forensic acute admission ward), many patients had escorted leave in the grounds and this was seen to be an effective way for patients to deal with stress. In some of the low secure areas and the PICU ward, patients had access to mobile phones during the day. There were innovative developments in dealing with areas that previously had been subject to blanket rules. For example, in the low secure areas the service was trialling the use of technology to randomly select patients for searching who were returning from leave rather than searching all patients every time.

During a six month period from 1 March 2015 to 9 September 2015 there were 102 incidents of restraint. It was noteworthy that this is a low number of restraints and emphasised the aim across the service to reduce the number of restrictive interventions. Most of these incidents occurred on Hulton, Lever and Shevington wards. Hulton ward reported 60 incidents of restraint, including 22 prone restraints. As part of the inspection, these were examined in detail and were noted to be for short duration (less than one minute) either to administer parenteral medication or when staff were exiting a seclusion room. There were 23 incidents of restraint on Lever ward, including two prone restraints and 11 incidents of restraint on Shevington ward,

with four of these being prone restraints. Again, on reviewing the records for these instances these were clinically indicated and for short periods. There were posters in observation lounges about restrictive practice and managing aggression with details about the dangers of restraint and prone restraint and information about alternative strategies. Service users had been involved in the format of these and approval sought via the patient's council. This reflected an aim to be open and transparent with patients about restrictive practices and how these might be used.

Conflict resolution training was mandatory training for staff. Following guidance around restrictive practice, MVA training had been reviewed to include alternatives to prone restraint and with an emphasis on verbal de-escalation and non-confrontational approaches. New staff highlighted that training at induction encouraged them to think of other options and several patients referred positively to nursing staff's verbal de-escalation skills.

There had been 24 incidents of seclusion in the six month period to September 2015. The majority of these, 14 incidents, were on Hulton ward. We examined six sets of seclusion records and found that the monitoring of patients in the seclusion room was completed in accordance with the provider's own policy and the Code of Practice. There was evidence seclusion was subject to medical review within one hour and 15 minute checks were clearly recorded in the seclusion pack. Two hourly independent nursing reviews were also clearly documented. Some of the seclusion documentation was not fully completed, but missing information could be found within the electronic patient records.

There were seven instances of long term segregation across four wards. There were concerns that on occasion long term segregation was actually continued seclusion. On occasion, when a patient in seclusion was beginning to settle, the door to the seclusion room would be unlocked allowing the patient access to the observation lounge. This was considered to be a less restrictive way of managing the patient. However, patients would be prevented from leaving the observation lounge due to the door remaining locked. At this point staff were terminating the episode of seclusion and wrongly recording this as the commencement of a period of long term segregation. This is not in keeping with the code of practice. Medical staff told us that the arrangement at The Spinney was that seclusion longer than a week was regraded to long term segregation. This is also not in keeping with the code of practice as this is continued seclusion. Long term segregation is planned and agreed by a multidisciplinary team and is subject to separate criteria than seclusion. The inspection team could understand the rationale for regrading seclusion on occasion particularly if there were plans in place for ending seclusion gradually, as the patient would not then be subject to regular reviews which they may find stressful or frustrating. However this is not in keeping with the revised code of practice.

There were observation lounges on each ward where patients were encouraged to spend time in order to take advantage of a less stimulating environment. On wards with seclusion rooms, these often formed part of the seclusion facility. These were used on occasion for de-escalation. Whilst this is good practice in terms of using a quiet area for de-escalation and a lower stimulus environment, there was some concern that patients may be subject to "de-facto" seclusion if they were not able to leave this area when they wish to. The four most recent such uses on Shevington ward were reviewed from care records. In two of these instances, restraint had been used as there had been a refusal by the patient to enter the observation lounge. In both instances, the patient had remained in the lounge for an unspecified period of time until their behaviour was calmer. The local procedure for use of observation lounges made clear that if the patient was not allowed to leave the area this should be recorded as a seclusion incident. In other areas with observation lounges, staff stressed that patients chose to use the room themselves with or without staff present and with no restrictions should they wish to leave. The rationale for using these lounges to provide least restrictive options for managing challenging or aggressive behaviour is clear and clinically reasoned, it was the need to ensure safeguards under the Mental Health Act were being followed that was the issue.

Safeguarding training was mandatory for all staff and at the time of this inspection 87% of staff were up to date. Staff understood what could constitute safeguarding concerns and reported appropriate action they would take. Social workers took the lead with safeguarding reporting and had links with the local borough council responsible. Safeguarding notifications and alerts were completed appropriately. Safeguarding flowcharts were displayed in ward offices.

Good

Forensic inpatient/secure wards

Medicines management on wards was good, with suitable premises and storage available. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, the relevant legal authorities for treatment were in place and nurses checked these when administering medicines. Medicines were securely stored. Staff completed checks of emergency medicines to ensure they were available if needed. Staff completed medicines reconciliation at admission.

Staff had a good understanding of safe medicines management and there was training for staff available. There was a comprehensive checklist completed each weekend by a qualified nurse looking at stock levels, consent to treatment compliance and clinic room checks.

The wards did not receive regular clinical support from a specialist mental health pharmacist. The pharmacy arrangements included provision for a clinical pharmacist but the pharmacist had left earlier in the year and there had been no replacement. There were stock checks and an audit completed once a month on most of the wards. There were no arrangements to ensure that patients in hospital were given an opportunity to meet a specialist mental health pharmacist to support medicines choices and information. There was also no input in overseeing complex medication regimes or changes to treatment. This was particularly relevant in areas of the service where medication changes were made frequently or where there was the use of rapid tranquillisation. The National Institute for Health and Care Excellence (NICE) guideline NG10 Violence and aggression: short-term management in mental health, health and community settings, NICE guideline QS14 service user experience in adult mental health services and the NAPICU standards refer to specialist pharmacy advice being available.

Therapeutic drug monitoring was completed and recorded for patients receiving medication such as clozapine that requires close monitoring. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines.

Patients saw a GP for their physical health needs. The GP prescribed any medicines or treatments required for the physical ailment they reviewed. The process of reviewing ongoing prescribing or access to specialist advice and support from a pharmacist was unclear. There was evidence of a short term medication inappropriately being prescribed over a longer term. This had not been identified by prescribers when the card was rewritten, and had not been picked up by the regular audits. The hospital took immediate remedial action to resolve this.

On Hulton ward, entries were not always made in patients nursing notes when 'when required' medication was administered. This information is useful to support review of treatment. Additionally, although not administered, three patients were prescribed an injection used for rapid tranquilisation at higher than the BNF [British National Formulary] maximum daily dose. The rationale for this was unclear but it appeared that the prescriber had used the previously authorised maximum doses for this medication rather than the newer limit. The maximum daily dose of this medicine was reduced in June 2014. This had not been identified by the prescriber or nursing staff despite regular audits carried out each week.

Two patients in the service were receiving antipsychotic treatment above BNF limits, which carries additional risks for the patient and is subject to extra physical health monitoring. Neither patient had an alert on their care records or recorded on the prescription card. There was a policy in place to monitor high dose antipsychotic treatment but this was not being followed. At a follow up visit in the week following inspection, a further two patients had been identified within the service who were on high dose antipsychotic treatment. There were arrangements in place by the time of this visit for increased monitoring.

There was a child visitor's policy which outlined arrangements for children visiting the hospital. Children were assessed before being approved to visit and this responsibility rested with the service social workers. Child visits were always supervised and for the initial visits social work staff supervise these. There was a child visiting room for these visits, which is away from the wards.

Track record on safety

In the last twelve months, eight serious incidents were reported within the hospital. These included three patients absconding whilst on escorted leave, two data protection breaches, a violent incident, a safeguarding incident and a physical injury. The service had completed serious and untoward incident investigations for all these.

Good

Forensic inpatient/secure wards

The service showed evidence it made improvements to safety as a result of adverse events, for example, in the appointment of a lead for safety and security following a previous incident.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and all staff had access to the electronic system for this.

Senior staff and ward managers attended the morning handover meeting where incidents were reviewed and actions planned.

Patients were given explanations and an apology when things went wrong. The patient liaison officer made contact with patients following resolution of complaints to ensure resolution was acceptable.

Staff received feedback from investigations in the service and the wider hospital group via a regular lessons learned bulletin.

Debriefs took place following incidents. Staff reported feeling supported by managers and multidisciplinary team members. There was evidence of patient involvement in debriefs.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at the care records of thirty patients. Care plans were up to date, personalised, holistic and recovery focussed. Patients told us they were involved in care planning and all had been offered copies of their care plans. Patients were involved in care plan reviews with the multidisciplinary teams at review meetings. Changes made during the meeting were inputted directly into the electronic notes and a projector was used so that all present could see changes made. Hulton ward completed comprehensive 72-hour care plans which included risk assessment at admission. On the secure wards there was a more extended period of assessment post admission.

There was a team responsible for physical health monitoring comprising of a full time practice nurse and a physical health assistant. A GP visited the service weekly. The GP registered patients and referred for specialist acute hospital advice as needed. The service had access to urgent out of hours GP provision. Allied health professionals, such as chiropody and optician services, visited at regular intervals.

Electronic dashboards monitored the completion of a physical assessment within 24 hours of admission. When the clinical records were examined, the physical examination section of this form was either partially completed or incomplete. This related to difficulties with the electronic patient record which only allowed the history and examination sections of the form to be completed in one attempt, although in practice the practice nurse and GP completed this respectively at different times. There were improvements being made to the recording of physical examinations within the electronic patient record, which would also enable blood results, scans and other correspondence to be scanned in the Spinney electronic record. On Hulton Ward, the duty consultant admitting the patient would undertake a physical examination at admission.

The GP visited the hospital for two hours per week and this time was spent addressing acute medical issues. At the time of inspection, there was no system in place for reviewing previous issues and treatment. At a subsequent visit a week later, there were appointments made for reviews of GP treatment with the practice nurse leading on this.

There was noted good practice in the form of arranging blood tests and routine electrocardiogram (ECG) on admission. Monitoring of cholesterol and blood sugar management was also completed regularly. Diabetic reviews were completed annually, including retinopathy screening and foot checks.

Physical health care plans were completed to a good standard.

The ward staff recorded routine physical observation checks for all patients monthly. One patient had refused all physical interventions since admission due to being acutely unwell and it was not clear if their capacity had been assessed in relation to his ongoing refusal of physical health monitoring.

There had been several initiatives around improving physical health and encouraging weight loss. There was a 13 week programme called "Mission Fit" in progress. This was run by a dedicated fitness instructor in conjunction with the practice nurse. It aimed to introduce concepts of physical fitness and healthy eating. Patients gave positive feedback about their involvement in this and clearly enjoyed this approach. This programme followed successful past initiatives to improve physical health and fitness. One previous initiative had been shortlisted for a national award. There was also a regular walking group that travelled to local areas, such as Rivington Pike, offering varied walks for all abilities.

Information was securely stored on an electronic records system. Information was readily available in terms of clinical notes and care plans. Mental Health Act documentation was also available electronically. As noted above, it was sometimes difficult to locate information regarding physical health and a new system of where information was recorded was being rolled out.

Best practice in treatment and care

Staff considered and referenced contemporary guidance, for example The National Institute for Health and Care Excellence guidance relating to violence and aggression and schizophrenia when formulating care plans. There was good practice relating to smoking cessation and advice which is in line with and related to NICE guidance.

A range of psychological therapies was available including evidence based group intervention programmes. Each ward had an allocated psychologist. There was a large psychology department and group and individual programmes were available in a wide range of therapies including the life minus violence programme, a sexual offending group programme, substance misuse groups including separate motivational and treatment groups, anxiety management and problem solving, alongside tailored individual work. Referrals were made via the multidisciplinary team or patients could self-refer. All patients had a psychological assessment completed.

Four patients raised issues regarding the length of time waiting to start the Life Minus Violence groupwork programme. Patients told us this was affecting discharge planning, for example, in meeting requirements for undertaking treatment plans laid down by parole boards or tribunal hearings. There were 12 patients referred for the next programme at the time of this inspection. The next course was due to start in January 2016 but would only have eight places. Patients who were not accepted on to this course would have to await the commencement of the next course. There was no clear indication how long these patients had already waited to access the required therapy. In the meantime, there were opportunities to access other types of psychological interventions.

Many patients were engaged in psychological therapies. Patients were able to self-refer for an assessment for treatment. During a care programme approach (CPA) meeting, a patient who refused to attend a therapy group was offered the same work on an individual basis so that he would still receive this intervention.

Risk assessments were completed using evidence based tools, including the standard use of the HCR-20 and START tools. Other standardised rating tools were in use, including the Health of the Nation Outcome Scales (HONOS), symptom rating scales and regular use of medication side effects questionnaires, for example the Liverpool University neuroleptic side effect rating scale (LUNSERS). Hesketh ward were piloting the use of a quality of life tool.

The wards undertook a number of audits and electronic dashboards enabled the teams to monitor completion of these. There were regular audits relating to a range of health and safety measures such as ligature risk audits, fridge temperature monitoring and daily checks of emergency equipment. In addition, audits were undertaken to monitor completion and regular reviews of care plans, assessments and risk management plans.

Skilled staff to deliver care

There were comprehensive multidisciplinary teams comprising medical, nursing, social work, occupational therapy (OT) and psychology staff. The service had well-staffed OT, social work and psychology departments.

All the staff we spoke with felt supported and spoke positively about the development opportunities available. One initiative introduced had been "swap-shop" sessions on Saturdays for staff to attend and develop skills or improve knowledge. Staff were able to attend and claim time owed if not on duty.

Nursing staff were required by hospital policy to have managerial supervision every four to six weeks. Managers audited management of staff sickness and absence,

training and supervision. Managers had access to a tracker to record this and alert them to those staff who were overdue. On reviewing supervision records, regular managerial supervision was not routinely taking place within these timescales.

- Lever ward – Three records reviewed.

One staff member had had supervision four times with the other two having had three supervision meetings during 2015.

- Hindsford ward - Four supervision records reviewed.

Supervision was recorded once for one staff member, twice for another member of staff, three times for another staff member and on four occasions for the fourth in 2015.

- Hulton ward - Four records were reviewed.

Staff had received supervision on average three times in 2015.

- Hesketh ward - records reviewed showed one member of staff had had supervision five times during the year, with other staff rates between 2 and 4 times over the year.
- Rivington ward - No records available for supervision.

Staff did not raise any concerns regarding frequency of supervision and said they felt well supported.

Staff meetings were also variable with the local policy that these would be monthly for day and night shifts. Records were available for four meetings of the expected ten on Lever ward, four minutes were available on Hindsford ward, two sets of minutes were available on Hesketh ward and only one set available to view on Rivington ward. Team meetings had taken place on Hulton ward approximately every two months.

The personnel files for five employees were reviewed. Checks confirmed staff were suitably checked to confirm they were appropriate to work with patients before they started work. This included disclosure and barring service checks and reference checks. There were also checks of qualifications and professional registration where appropriate.

Staff received an annual appraisal of their work performance. The service was close to 100% in terms of completed staff appraisals. All medical staff had been revalidated where this was required.

New staff, including bank staff, received a comprehensive induction programme prior to commencing work on the wards.

Qualified nursing staff reported feeling supported to develop their skills. Several staff mentioned leadership and management training was available. The practice nurse had completed additional training to support her role and the physical health assistant was nearing completion of a two-year diploma course.

Health care workers (HCW) described the support offered to them as excellent. On starting employment, there was a mentor assigned who was a more senior health care worker. There was a series of progression points for health care workers with increased pay and more responsibility. These were portfolio and competency based and subject to interview. HCW's described good training and many spoke of the learning packs available covering subjects such as mental health awareness and personality disorder.

There was clear flexibility to develop posts where needed. For example, a post was created whereby a member of staff was available to escort visitors for professional and family visits. Given the large geographical site of the hospital and the security aspects of visiting this had been successful in ensuring that visitors did not wait long in the reception area before going to their destination.

Multi-disciplinary and inter-agency team work

Staff and patients spoke positively about the multidisciplinary teams (MDT). MDT working was evident in meeting minutes and interviews with staff and patients. There was a good understanding of the roles of the MDT and patients and nursing staff reported other professionals being easily accessible if needed. MDT meetings were held weekly on all the wards.

We observed one MDT meeting and two care programme approach (CPA) meetings. Different professions worked well to assess and plan patient care and treatment. Patients were central to decision making and discussion. Patients could attend for the whole meeting if they wished.

There was effective local community liaison and partnership working evident. During our visit, we met with several local organisations that have developed vocational

work placements for patients. We were also able to observe a community session at the local resource centre where patients and local residents learned basic life support techniques.

Adherence to the MHA and the MHA Code of Practice

Staff had a good understanding of the Mental Health Act and the related code of practice, and 96% of staff had completed training on them. Changes to the Mental Health Act code of practice in 2015 had been implemented and staff were aware of these.

The Mental Health Act administrator was highly knowledgeable about the Act and provided training for staff, including an initial session as part of the induction programme. The administrator provided advice for staff and ensured the mental health review tribunals and hospital manager appeals processes ran effectively.

All detention papers were received and checked by the Mental Health Act administrator. All detention papers reviewed during this inspection were present and correct.

Patients reported having their rights read to them regularly and clinical notes confirmed this. We saw evidence that were patients were not considered to have understood information, this was attempted again.

Copies of 'consent to treatment' authorisation forms copies were stored with medication charts.

Section 17 leave was recorded appropriately. We reviewed section 17 leave for a sample of the detained patients. Leave was authorised by the responsible clinician and recorded on the electronic system. There was evidence that the authorisation of leave was linked to a comprehensive risk assessment. We did not find that there were any issues with leave being facilitated and patients told us that their leave tended to go ahead as planned.

Patients reported good advocacy provision. An independent mental health advocate (IMHA) was available on site four days a week. The advocate had an office in the drop-in centre in the grounds. Patients could ask for advocacy or staff would make contact on their behalf. Posters and information regarding this were displayed throughout the service.

A Mental Health Act reviewer completed two monitoring visits during this inspection on Shevington ward and Hesketh ward.

Good practice in applying the MCA

Knowledge of the core principles of the Act was variable. Across the staff team, some could give good examples of the use of the Act in their day-to-day working. There were a number, however, whose knowledge was poor. Lack of understanding of this law could lead to patients not being involved in decisions about their care because staff did not understand or assess their capacity to make decisions.

Training for all staff in the principles of the Mental Capacity Act had recently been introduced and was being coordinated by the provider. A number of staff had recently attended prior to inspection. There was an elearning package available for staff. These were recently introduced and there will likely be improvement in knowledge as staff attend training.

There was no use of deprivation of liberty safeguards at this service.

Are forensic inpatient/secure wards caring?

Outstanding ☆

Kindness, dignity, respect and support

The inspection team were impressed by the respect and value placed on patients within this service. We were given consistently positive feedback from patients and others about staff within the service and the management of the service. The emphasis on patient involvement particularly impressive given the need to balance care with security and necessary restrictions as part of a forensic service.

We felt people were truly respected and valued as individuals. There was evidence of patients being active partners in their care. For example, this was demonstrated in the shared undertaking of care planning and risk assessments. During review meetings, patients and staff together reviewed and updated care plans. We saw examples of innovative activity planning and leave used to balance risks with providing individualised care. Staff always empowered patients to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care.

There was a strong, visible person-centred culture. Staff were highly motivated and

inspired to offer care that is kind and promotes people's dignity. Staff had good knowledge of the patients in their care. Relationships between people who use the service, those close to them and staff are strong, caring and supportive. These relationships were valued by staff and promoted by leaders. Patients reported staff being available to speak to them when needed and several praised de-escalation skills staff possessed. Staff were described as friendly, approachable, polite and respectful. Patients reported feeling involved in care decisions. During this inspection, inspection team members witnessed many positive and caring interactions between staff and patients.

The involvement of people in the care they receive

At the beginning of the inspection, patients, staff and the service director gave a presentation and overview of the service with their achievements and plans for the future. There was a presentation by members of the patient's council explaining how this worked and achievements to date. There was clear evidence of putting patients at the centre of the service and involving and empowering patients at all levels. Within the service and the culture this was clearly embedded.

Examples of this included the contributions that patients made to the hospital clinical governance committee and the role of the patient's council in giving patients a strong voice and power in the running of the service.

The patient's council met once per month. The service director chaired this and representatives from each ward attended. Issues raised and actions taken would feed back into the ward community meetings and upwards into the hospital governance meeting. Patients were actively involved in plans being made around the service and shaping these.

The council had real power in being able to agree funding for hospital and ward based equipment or provision, for example, funding to build and upkeep a running track. Other changes were agreed, for example, the original corporate posters regarding restrictive interventions were re-designed by a group from the council to be more user friendly and were then agreed within the clinical governance meeting.

Funds were allocated to be spent directly on resources which would make a difference to patients. The use of these funds was decided by patients on the ward and fed back into the council at the monthly meetings. We were able to see how suggestions for funds or changes to the service were considered and often requests or changes were agreed. If there were issues identified, this did not automatically mean that suggestions were dismissed, rather there was clear evidence of discussions of how changes could be made. The service director led this and it was clearly supported by all the staff we met. Patients were partners in their care.

A patient representative from the council attended the hospital governance meeting. The minutes of these meetings capture discussions and consideration of changes and give a real sense of the contribution of patients to these meetings as being respected and valued.

Patients interviewed staff and a patient representative was on the panel for all staff interviews. A number of patients had completed training in interviewing and there were a number of patients across the service available to attend interview panels. This ensured there was a number of people who could fulfil this role.

There were fortnightly community meetings on each ward. Patients chaired these where possible. Minutes show these were used to discuss forthcoming activities and events, update about changes on the ward and provide information about the service. Patients could raise problems or concerns within these and there was evidence that these were actioned. They were also an opportunity to allow for discussion around relationships and interpersonal issues on occasion. The minutes of these fed into the patient's council and the hospital governance meetings.

During care programme approach meetings, patients were at the centre of discussions. Patients were involved in the planning of these and who to invite, including carers, family, and friends. They could chair their own meetings. There was open and honest discussion around next steps, risk management and care planning. Care plans and risk assessments were reviewed and updated within the meeting allowing discussion and agreement with patients and staff.

Patients reported being involved in activity planning with an emphasis on their own individual needs and interests. Staff reported a "can do" mentality across disciplines, with an attitude spoken of from different individuals across the service that rather than saying "no, we don't do that here"

the approach was "could we make that happen?" There were creative and innovative approaches towards education and employment, which are described in more detail elsewhere in this report.

There was an annual patient survey, which asked about involvement in all aspects of care. There was a response rate of 54% for the 2015 survey. There were high levels of patient satisfaction reported in terms of involvement in care planning and awareness of treatment plans. Most patients felt treated with respect and listened to. An action plan was in place to address specific issues and areas for improvement. Patients leaving the PICU service completed a discharge survey to identify areas for improvement and gather feedback.

Carer's provision was being reviewed, with several carers keen to be more involved in training and governance. Carers were sent a newsletter four times per year. Patients were involved in writing and producing this. There were plans for carers to be involved in customer care training and they had been involved in creating a video for customer care training for staff. A carer's representative was being recruited to attend the governance forum. An annual carer's survey was completed. There were regular carer's days organised and a carers Christmas lunch had proved successful. This had enabled patients to eat Christmas lunch with their families.

All wards had availability for the use of skype located in a quiet room to allow for communication with family and friends who may be unable to visit regularly. The provision of this across each ward in the service, easily accessible to patients, in comfortable private surroundings, was excellent. Use of these facilities was not exceptional as in some services but was seen as a usual way that many patients would ordinarily use technology to keep in touch with friends and family.

Patients reported good advocacy provision. An independent mental health advocate (IMHA) was available on site four days per week. The advocate had an office located within the drop in centre in the grounds. Patients could self-refer for advocacy or staff could contact on their behalf.

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

(for example, to feedback?)

Outstanding ☆

Access and discharge

The service offered psychiatric intensive care, low and medium secure provision within a national catchment area. Only the intensive care service offered emergency admission.

Referrals were made to the forensic service and representatives from the multidisciplinary team completed the assessment. At the next morning handover meeting of senior staff a decision would be made regarding admission.

The PICU service accepted telephone referrals, with use of a triage tool to identify if admission was suitable. There were clear inclusion and exclusion criteria for admission.

Moves between wards in the service took place in a planned way. There was a clear pathway through the medium and low secure services. Information was available on all wards about the service provided. There were clear distinctions between the low secure and medium secure wards. On Hindsford ward patients were given a leaflet explaining the difference between the care within the low and medium secure services, and the difference between this ward and the other low secure ward.

Delays occurred in the movement of patients from medium to low secure provision, patients could only be stepped down to low secure wards within the hospital if this was agreed with the home area mental health team. There were also delays in moving patients to local area provision due to difficulties in identifying a suitable placement for patients to be discharged to. Commissioners from NHS England were aware of some of these difficulties and maintained links with commissioners and care co-ordinators in other areas to attempt to resolve them. There were sometimes difficulties for care co-ordinators in attending CPA meetings. The provider ensured videolink facilities were available and care teams from a distance often contributed to meetings this way. Staff had also used teleconferencing facilities on occasion. These strategies for ensuring contact was maintained with care co-ordinators and home teams was excellent practice.

Information booklets were provided on admission that covered useful information about the service. The patient council had assisted in writing these to ensure they reflected relevant information.

Some patients when interviewed felt their treatment was delayed, with issues raised about delays in moving on to lower security and delays waiting for psychological provision.

The facilities promote recovery, comfort, dignity and confidentiality

All wards had a range of facilities available to promote recovery. Every ward had a kitchen available for hot and cold drinks and snacks which patients could use at any time. There were also rehabilitation kitchens on all wards for cooking sessions to take place, after appropriate risk assessments had been undertaken. There were quiet rooms on each ward. On every ward, there were areas where staff and patients could speak privately. Each ward had a payphone within a room to enable private conversations.

Rivington ward, was uncomfortably warm when we visited with a wall temperature indicating 23 degrees. The heating controls were shared with Hindsford ward and overseen by the maintenance department. Requests to change the heating level had been made to the maintenance team but this was not changed by the time of the visit. Patients on Hindsford ward complained that the ward was too hot.

Bedrooms were spacious. Inbuilt storage was provided, including cupboards, wardrobes and television cabinets. On some wards rooms had en suite bathrooms. On wards without en suite bathrooms, there were sink areas in the bedrooms and adequate access to shower and bathing facilities. Patients could personalise their rooms and we saw rooms with pictures and posters and individual possessions. Some patients had game consoles and televisions in their bedrooms. Lockers were available for restricted items such as glass toiletries. Most patients had keys to their own bedrooms and this was individually risk assessed.

Visiting rooms were available for each of the wards visited. Most of these were off the main ward area, which provided a more private environment for visits. A separate visiting room was available for visits with children. Patients told us they were able to arrange visits with family and friends. All wards had availability for the use of skype located in a quiet room to allow for communication with family and friends who may be unable to visit regularly.

Most patients felt the food was of a good standard. There were some comments regarding the halal diet being not spicy enough, small portions and restricted choices. Several patients noted that the occasional unit wide takeaway meal was often fish and chips; however this seemed to be the majority choice. The menus available showed a choice of meals and healthy options and diet choices clearly marked. It was noted that the chef would speak to individuals if there were concerns or complaints raised about food. We sampled the food during the inspection and it was of a good standard. Notable good practice was that at mealtimes staff would sit and eat meals with patients.

Outside space was available to patients on each ward, with set access during the day for cigarette breaks. Patients could request additional time to sit outside or go for walks within the secure area. There was a running track for use by patients within the secure perimeter. This had been provided in response to discussions with the patient council.

The hospital grounds provided a large area for walks and a fishing lake was available for freshwater fishing. There was a drop-in centre within the grounds to allow patients to meet up socially. Patients generally reported no difficulties accessing leave. Some patients on Hindsford ward were able to access regular home leave, which they enjoyed.

Within the main hospital, there was provision for varied activities, including a gymnasium, swimming pool, sports hall, art rooms, social room, photography suite and music room. There were allotments within the secure area of the grounds. Activities were available in the evenings and at weekends, including occupational therapy (OT) staff working at weekends. We saw planned community activities arranged in the evenings, with unit based activities including games tournaments, cinema club and use of the sports hall for team sports. Patients on the PICU ward benefitted from activities on the ward as well as low key psychology sessions, for example a regular mindfulness group and group OT sessions including cooking sessions and relaxation groups.

Good

Forensic inpatient/secure wards

Patients described being involved in identifying interests and activities and were planned to meet their needs. Patients could self refer for activities that they were interested in. OT staff spoke of focusing upon supporting patients to develop new skills and interests and ensuring maintenance and re-discovery of existing skills and talents. The hospital had a target of a minimum of 25 hours activity per week. In the records we reviewed, this was happening and some patients were far exceeding this level with meaningful, structured activity. There was also a focus on individual engagement and relationship building with patients who may have lower levels of motivation due to chronic illness by the OT and ward based staff.

There was access to education, with courses offered in literacy and numeracy. On an individual basis, learning that was more specific could be planned and this included distance learning and open university programmes.

The hospital had two pets as therapy dogs regularly on site and patients helped look after them and take them for walks in the grounds. Hindsford ward patients had agreed to the purchase of a ward cockatoo. The decision had been made by the patients. There were plans to adopt two guinea pigs in the near future.

There was a focus on smoking cessation across the service. There were good links with the local NHS smoking cessation service and several staff had achieved level one training. One patient representative had also completed the training. There was a session arranged for medical staff around good practice in prescribing nicotine replacement.

There was an emphasis on improving access to employment. There were internal work opportunities available to patients on a 12 week rolling basis. These included woodwork posts, painting and decorating, gardening, warehouse and assistant roles with the unit shop and food serving within the kitchens being organised.

The occupational therapy team had good links with a wide range of community initiatives offering real life work placements, including the guide dog for the blind centre, local sports clubs and schools. Members of the inspection team were able to meet representatives from these services and patients who have been involved and received positive feedback about these initiatives. Services such as designing crafts, painting and decorating, wood work, gardening and voluntary work had been supplied to several local services and money earned had been reinvested in helping this scheme to grow.

There was support to gain qualifications such as health and safety, food hygiene, basic life support and a BTEC award in work skills.

Patients had submitted art and photography work to the national Koestler awards. The service had participated for a number of years and patients had regularly won awards. Patients had attended the National Service User awards and been shortlisted for several awards. This was an ongoing commitment from the service having been shortlisted and won awards previously. One of the patients was a judge for this year's awards.

Patient-led assessments of the care environment (PLACE) assessments took place regularly with results analysed and acted upon.

Meeting the needs of all people who use the service

There were adjustments made for people living with a disability. Accommodation could be provided in ground floor areas and wards with bedrooms on the upper floors could be accessed by lifts if needed.

Information leaflets were available in other languages if needed. Interpreter services were available and accessed as needed. Patients were given information booklets and welcome packs when they were admitted to the service.

There was a choice of food and specific religious and ethnic groups were accommodated. The chef was also available to discuss more specific requirements if needed.

Patients described good spiritual support and being able to access religious services at a place of worship of their choosing. Male staff facilitated leave to the local mosque as required. An imam and a minister visited regularly as required.

Patients could access Afro-Caribbean mental health projects in central Manchester with staff.

Patients could not effectively self-medicate on Lever Ward as there were no appropriate medication storage facilities to enable this. Two patients on Lever ward were supported to self-administer their own medicines. However, their medicines were kept centrally because facilities for the

individual storage of medicines were not available on the ward. On Hindsford ward, the majority of patients were self medicating and stored medication securely in their own bedrooms.

We reviewed the care planning related to end of life care for one patient and found this sensitively planned, personalised and meaningful, despite the environmental and legal restrictions of secure care.

Listening to and learning from concerns and complaints

Between August 2014 and September 2015 there were 121 complaints across the hospital. 115 of these were informal with all resolved and no further action required. There were 6 complaints which had required formal investigation. Of the six formal complaints, three were upheld, two were not upheld and one was partially upheld. No complaints had been referred to the ombudsman.

Patients were aware of how to complain and there was information on each ward about the complaints process. Staff recorded complaints and the local process on wards of aiming to resolve complaints rapidly at a local level worked well. Complaints books showed complaints made and recorded and then a record of actions to resolve this and whether this had needed escalating. The patient liaison lead regularly reviewed the complaints books. The patient and staff signed to agree an accurate record and when a complaint was resolved.

Patients who had used the complaints process were satisfied with the outcome.

Staff received feedback regarding specific issues by email and lessons learned were also circulated to staff by email. The patient liaison officer also completed monthly themed reports around complaints.

Duty of Candour

Staff demonstrated good understanding of their responsibilities regarding duty of candour.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

Partnership in Care has corporate values which were

- Valuing people
- Caring safely
- Integrity
- Working together
- Quality

Staff knew of these values and they were displayed throughout the hospital. Individual staff reported feeling valued, enjoyed their work and felt they had a “voice” as a member of the multidisciplinary team. There was evidence of how these values informed the delivery of care. At the start of the inspection representatives from the patient council attended and gave a presentation detailing the service user involvement within all areas of the hospital.

There was a patient representative on the governance committee and the hospital was expanding the remit to include carer representation.

There was reference to an “open-door” policy where senior staff were approachable and available to staff. There was good communication from daily handovers and via email in the form of team briefs and lessons learned.

Staff gave examples of occasions when senior management have offered intensive support to staff at times of high acuity in admissions, for example. Senior managers undertake regular “ward walks” and are visible and known to staff on the wards.

Good governance

There was a governance structure in place, which ensured information moved from ward to board and board to ward. There were patient community meetings, ward management meetings and clinical operational department meetings. These meetings took place regularly and fed in to the hospital management and clinical governance group.

The registered manager and the governance leads undertook quality visits to wards. These visits included representation from all disciplines including patients. They had a ‘five point rule’ where they asked staff about five things communicated recently to audit whether information was being communicated effectively. This was an excellent initiative and allowed the service to quickly identify whether communication had been effective or further work was needed.

Good

Forensic inpatient/secure wards

The hospital committee had direct links into the regional management committee and clinical governance group of the Partnerships in Care organisation. These then reported to the board via corporate management committee and corporate clinical governance.

Daily handover meetings of senior management and clinical staff ensured there was good oversight of all issues affecting patient care and the hospital overall. These were described by those who attended as informative, structured and constructive. They were evidence of good leadership. There was good oversight of staffing levels and issues, captured within daily handover meetings. These enabled a resource manager to then lead with booking additional staff via the staff bank or agency cover if needed.

Ward managers were experienced and provided clear leadership to the wards they managed. They had sufficient authority to make changes required within their own areas. They had support from the clinical nurse managers and service director. Administrative support was in place for all wards except Hulton ward, and on this ward staff described spending time frequently answering the phone and overseeing the ward office which impacted on time available for care.

There were systems in place to monitor staff training, sickness, supervision and appraisals. However, figures from these trackers were not necessarily found to align when checked at a ward level. For example, supervision figures showed a high number of staff receiving supervision at the correct intervals but ward based supervision records did not show this. Although dates for line management supervision were booked in advance throughout the year these actual meetings appeared to happen inconsistently. When the line management documents were audited during this inspection a number of the supervisions arranged appeared not to have occurred.

There were difficulties highlighted in terms of maintenance requests and the process for these. Requests were made by email, but there was no centralised tracking of these that could be accessed by staff. There were reports of requests being repeatedly made as there was no way of checking if this reporting had already been done. Once requested, there was no feedback regarding the request and no system for prioritising requests.

In terms of external contracts the pharmacy service was contracted to provide clinical pharmacy input but this was not happening in line with the contract.

Leadership, morale and staff engagement

Staff reported feeling valued and supported by the service. On the wards we visited, staff described morale as good and felt supported and valued by the organisation. There were staff benefits including childcare vouchers and provision, gym use and meals whilst on duty. Staff received accolades and acknowledgements linked to length of time employed in the service and these made them feel valued and appreciated.

Health care workers were supported with continuous development. Qualified nurses felt supported to develop and there was access to leadership and management training and other training identified as part of the appraisal process.

The hospital did a 'swap shop' monthly on a Saturday. This was where senior staff were available for one to one meetings with staff. Those who attended were paid if they were not on duty and drop in sessions were available to help staff build skills and confidence in a variety of areas for example, security and was provided as part of ongoing professional development and learning.

Staff sickness levels were low at 3%. Nursing staff sickness/absence figures over the year were below 5% except for one month, April 2015, with a figure of 6%.

There was a staff consultative meeting led by the service director held each month. This allowed staff to raise concerns, request maintenance and equipment and discuss staff support. Initiatives such as a relaxation day with access to complementary therapies had been organised.

Staff described the service director regularly visiting the wards and accessible to patients and staff.

There was an annual staff survey with results formulated into an action plan which was monitored through the staff consultative meeting.

An employment engagement lead post was being trialled, with an emphasis on improving retention of staff across the organisation including the Spinney.

Good

Forensic inpatient/secure wards

Regular team briefs were circulated by email to keep staff aware of developments at this hospital and within the organisation.

Staff reporting feeling able to raise ideas and or concerns to service managers and for their views to be listened to and acted on.

There was a national confidential 24 hour concern line available to staff to raise concerns. There were posters around the service advertising this.

Commitment to quality improvement and innovation

There was a clear commitment to improvement and innovation. Patient involvement in the service was an ongoing process and was driven by service users and the staff team.

Staff and patient surveys were regularly undertaken and action plans formulated to make improvements.

The Spinney used the Commissioning for Quality and Innovation framework as additional quality indicators to work to and benchmark against. Currently these included the use of the Lester tool for metabolic screening, collaborative risk assessment (involving patients in formulating and updating risk assessments) and implementing quality dashboards. There were clear timescales and action plans which were regularly reviewed.

The low and medium secure services participated in the quality network review accreditation scheme overseen by the Royal College of Psychiatrists. The most recent published reports from October 2014 indicated compliance with the standards for secure care and positive practice outlined in the reports.

The psychiatric intensive care service was working towards the national association of psychiatric intensive care units standards for PICU care.

Outstanding practice and areas for improvement

Outstanding practice

There was a clear focus within the service on patient involvement. This included interviewing staff and a clear commitment to the patient's council and this feeding in to the governance structure. The patient's council had real power and influence in shaping the service. The service director chaired this and representatives from each ward attended. Issues raised and actions taken would feed back into the ward community meetings and upwards into the hospital governance meeting. Patients were actively involved in plans being made around the service and shaping these. Patient representatives also attended the hospital governance meetings.

There was an emphasis on improving access to employment. There were internal work opportunities available to patients on a 12 week rolling basis. These included woodwork posts, painting and decorating, gardening, warehouse and assistant roles with the unit shop and food serving within the kitchens being organised. The occupational therapy team had good links with a wide range of community initiatives who were offering real life work placements, including the guide dog for the blind centre, local sports clubs and schools.

Patients could gain qualifications such as health and safety, food hygiene, basic life support and a BTEC award in work skills. Services such as designing crafts, painting and decorating, wood work, gardening and voluntary work had been supplied to several local services and money that was earned had been reinvested in helping this scheme to grow.

The use of technology within the service was innovative. Skype facilities were widely and readily available to allow patients to keep in contact with family and friends frequently, which is important given that the service takes patients from across England and Wales. Similarly, videolink facilities were available to allow care co-ordinators to contribute to clinical reviews if they were unable to attend due to distance or other commitments.

The carers Christmas lunch was an imaginative way to allow patients to spend time with their families when they may have been unable to do this otherwise, for example, due to leave restrictions. The hospital had catered for this and organised additional resources, such as a photobooth to enable family pictures.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff follow procedures around medicines management, including rapid tranquillisation and high dose antipsychotic monitoring.
- The provider must ensure seclusion and long term segregation is correctly recorded
- The provider must ensure risk assessments are completed at admission

Action the provider SHOULD take to improve

- The provider should ensure all identified staff receive immediate life support training
- The provider should ensure that blanket restrictions on patients' freedom on the secure wards are reviewed to see if they are required to manage the risks to all patients
- The provider should ensure that staff should ensure prompt disposal of clinical waste bags on Pennington ward
- The provider should ensure that staff record the results of physical examinations of patients on admission in the hospital electronic clinical record
- The provider should ensure that managers provide staff with regular, documented managerial supervision in line with its own policy
- The provider should ensure that staff meetings are held regularly and documented
- The provider should ensure that staff record all uses of the observation lounges clearly and ensure that seclusion procedures are followed where necessary
- The provider should ensure that the Life Minus Violence programme waiting list is reviewed and that patients are kept informed of the waiting time and reasons for it

Outstanding practice and areas for improvement

- The provider should ensure that staff on all wards have a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards, and the implications for their practice
- The provider should ensure that the policy on self-medication is reviewed and provide storage facilities to enable it to be followed on Lever ward
- The provider should ensure that the system for requesting maintenance work on the hospital is changed to include a way to prioritise requests and track progress.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment **How the regulation was not being met:** Risk assessments were not completed for every patient at admission. This was a breach of regulation 12 (2) (a) We found concerns with the inappropriate length of treatment, a lack of monitoring of high dose medication and inappropriate prescribing of high dose medication. This was a breach of regulation 12 (2) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person centred care **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Patients had been prevented from leaving an observation lounge for a period of time and this was not recorded as seclusion and episodes of seclusion have been categorised as long term segregation when they should have been continued seclusion episodes.

This was a breach of regulation 9 (6)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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