

Kemple View

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

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 inspected Kemple View on 26-28 October 2015 as part of our ongoing comprehensive mental health inspection programme.

We rated Kemple View as outstanding because:

All the wards provided safe, secure environments. There were effective systems to maintain safety and security.

In April 2015, the low secure service had been reviewed by the Royal College of Psychiatrists quality network review team in April 2015 and fully met 95% of low secure standards, compared with a national benchmark of 81%.

The ward environments were generally clean and in good repair. There were some environmental issues but there was appropriate environmental assessment and mitigation.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Managers responded to any staff shortages quickly.

All the wards operated some restrictive practices that applied to all patients. It was recognised that some restrictive practices were necessary for environmental security and patient safety purposes. The service was operating in accordance with company policies. There was a clear culture of least restrictive practice and positive risk taking that was embedded across the service. There was a “least restrictive practice” champion on each ward, and efforts had been made to relax restrictions in some areas.

There was a strong recovery focused ethos. The hospital worked within the principles of the recovery model. This meant they focused on helping patients to be in control of their lives and building their resilience so that they could regain a meaningful life. Staff worked collaboratively with patients to promote recovery and include them in every aspect of care delivery. Patients and staff worked together to plan care and treatment in line with current evidence-based guidance. A recovery champion on each ward was responsible for offering advice and support to other staff and disseminating information. Patients contributed to their own care records, including planning for their discharge.

Staff received training in de-escalation and management of violence and aggression techniques. They were using “reinforce appropriate, implode disruptive” (RAID) techniques that used positive behaviour reinforcement to deal with potentially violent situations. RAID training is accredited by the association for psychological therapies. Kemple View was recognised as a RAID centre of excellence. RAID is a recognised industry standard method of working with patients to help them manage their own behaviour, accredited by the association for psychological therapies. Being recognised as a RAID Centre of Excellence means that that the organisation is implementing RAID principles outstandingly well.

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. For example, following leadership training, staff were encouraged to develop a piece of innovative work to implement on their ward.

Case formulation and reflective practice groups were available for all staff at each ward. Most of the staff we spoke with said they found discussion of challenging clinical issues invaluable in exploring ways to improve the service they provided.

Staff respected and valued patients as individuals and empowered them as partners in their care. There was a strong, visible person-centred culture. Putting patients at the centre of the service, involving and empowering them was clearly embedded. Staff treated patients with dignity, respect and kindness and the relationships between them were positive. These relationships were highly valued by staff and promoted by leaders both at ward level and by the senior management team.

The emphasis on patient involvement was clearly evident across the hospital. We saw a genuine commitment from all staff. Patients were involved in recruiting staff and the patients’ council was represented at all levels including governance. Each ward was represented on the patients’ council and a patient representative chaired the meetings supported by the hospital director. Issues raised and actions taken were fed back into community meetings on the wards and to the hospital governance

Summary of findings

meetings. Patients were actively involved in plans for service developments and improvements. They were involved in the review of complaints via the patients' council.

Staff offered support to patients' families and friends. For example, visitors were offered assistance with transport where they needed it in order to be able to visit their relatives. There was excellent support for patients and their families in the use of technology. Skype facilities were available so that patients could more easily maintain their relationships with the people close to them, particularly where there was significant distance. As well as assisting patients, the service had invested time in familiarising patients' friends and families with the use of Skype.

Care and treatment was coordinated with other services and other providers. Staff used technology to help ensure this. For example, tele- and video-conferencing were being used so that external care co-ordinators who might otherwise be unable to attend could contribute to care programme approach meetings. Staff worked closely with care coordinators to ensure that patients were helped through their discharge. Discharges or transfers were discussed in the multidisciplinary team (MDT) meeting and managed in a planned and coordinated way.

The use of projectors during care programme approach meetings ensured patients had the opportunity to comment on the report as it was written and enhanced their involvement in their care and treatment.

Patients were encouraged and supported to use community facilities wherever possible, reflecting the focus on normalising behaviour and life in the wider community. This enabled patients to take part in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to. There were established positive working relationships with other service providers, such as GPs and community services and groups. The involvement of other organisations and the local community was integral to how care and treatment was planned and ensured that the hospital met patients' needs. For example, they could attend neighbourhood groups, learning, vocational or volunteer opportunities. This reinforced the strong emphasis on improving access

to education and employment opportunities, both within the hospital and in the community. Patients could access vocational and academic courses, plus basic skills such as numeracy and literacy.

Many patients had access to a range of "real work" opportunities, both on-site and in the community. Patients applied and were interviewed for these posts and received reimbursement for the work they carried out. This reinforced the strong emphasis on improving access to education and employment opportunities, both within the hospital and in the community. There was a clear culture of positive risk taking.

Patients were involved in the review of complaints via the patients' council.

There was an effective governance structure to oversee the operation of the hospital and drive delivery of high quality person-centred care. Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. The hospital had developed services in line with national programmes of audit and quality.

The hospital operated a 'ward to board' model of governance that encouraged and supported staff involvement in the governance process.

Patients had opportunities to get involved in hospital governance and they were actively involved in plans for service developments and improvements. The patients' council had a strong voice and was represented at all levels. Rigorous and constructive challenge from patients was welcomed and viewed as a way of holding services to account.

The hospital used feedback from patients from annual surveys, ward quality matters, and patient-reported outcomes to inform and prioritise improvements in patient experience and care.

Staff surveys indicated high levels of staff satisfaction. Staff we spoke with were proud of the organisation as a place to work.

Leaders encouraged continuous improvement and there was excellent commitment to quality improvement. Staff were motivated to deliver change. There was a culture of collective responsibility across the hospital.

However:

Summary of findings



On Elmhurst ward, although the bathrooms and shower facilities were cleaned regularly, there was black mould around the silicone seals.

All the wards had enclosed garden areas but patients were only allowed access to them with a member of staff and the door to the garden was locked.

Some staff on Kenton ward were not aware of the reflective practice groups. This is a concern given the nature of the challenging work carried out on this ward.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Outstanding 	<p>There was a strong emphasis on patient involvement in all aspects of the service. We saw a genuine commitment from all staff. Staff respected and valued patients as individuals and empowered them as partners in their care. There was a clearly embedded and visible person-centred culture. There was a clear recovery focused ethos. Staff helped patients to be in control of their lives and build their resilience so that they could regain a meaningful life. Patients and staff worked together to plan care and treatment.</p> <p>There was an effective governance structure to drive the delivery of high quality person-centred care and promote equality and diversity. There was excellent commitment to quality improvement and a culture of collective responsibility across the service.</p>
Long stay/ rehabilitation mental health wards for working-age adults	Outstanding 	

Summary of findings

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Outstanding



Kemple View

Services we looked at

Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Kemple View

Kemple View is an independent hospital that is part of the Partnerships in Care group. It is situated in Langho, near Blackburn, Lancashire. The hospital provides services for up to 90 men with mental health needs, learning disabilities and problems with substance misuse. There are four low secure wards and two locked rehabilitation wards. Kemple View 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 has a registered manager. We inspected all four low secure wards at Kemple View:

- Arkwright is a 10 bedded ward for older men with physical health conditions
- Elmhurst is a 19 bedded ward for men with challenging and complex mental health needs
- Kenton is an 11 bedded ward for men undergoing a sexual behaviour modification programme

- Wainwright is a 16 bedded ward for men with personality disorder and dual mental health needs.

During the inspection, there were 56 men receiving low secure care at Kemple View. All were detained under the Mental Health Act 1983.

We inspected the two rehabilitation wards at Kemple View:

- Hawthorn is a 15 bedded ward with a high dependency focus for patients requiring additional support in their recovery
- Oakwood is a 19 bedded ward with a community focus.

During the inspection, there were 34 men receiving rehabilitation care at Kemple View. All but one were detained under the Mental Health Act 1983.

The Care Quality Commission has inspected Kemple View on four previous occasions since 2010. The last comprehensive inspection of Kemple View was on 16 April 2013. The hospital was meeting the essential standards of quality and safety.

Our inspection team

Inspection team leader: Annette Gaskell

The team that inspected the service comprised three CQC inspectors, a Mental Health Act reviewer, two specialist advisors with experience of nursing in secure services and

one expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses a health, mental health or social care service.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location. We carried out announced visits to the service on 26, 27 and 28 October 2015. During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- carried out a Mental Health Act monitoring visit on Elmhurst ward
- met with 29 patients who were using the service
- left confidential comment boxes on all wards and collected feedback from 17 patients
- attended and observed one ward community meeting
- met with one relative of a patient
- met with the registered manager and the managers or acting managers for each of the wards
- met with 46 other staff members including doctors, nurses, occupational therapists, psychiatrists,

- psychologists, social workers, support workers, the Mental Health Act co-ordinator and Mental Health Act administrator, other administrative staff and staff working in education and development
- met with the independent mental health advocate
- attended and observed three hand-over meetings and three multidisciplinary meetings
- attended a mission fit session
- visited the education suite, the music room, the art room, IT suite, the sports hall, the multifaith room, the horticulture area and the on-site café
- looked at care and treatment records of 33 patients, including risk assessments and care plans
- carried out a check of the medication management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at 24 staff records.

What people who use the service say

We met with 29 patients who were receiving low secure care and collected feedback from 13 comment cards.

Patients told us they felt well supported by the staff. They said the staff were exceptional in the care and support they provided. All agreed that the staff were approachable, available and caring, including bank staff. They said staff treated them with respect and listened to them. Patients felt they had good relationships with all staff. Some said staff went out of their way to ensure their needs were met. One said the staff believe they can improve patients' quality of life and go the extra mile.

Patients told us that care planning was progressive and goal-led. They said staff actively encouraged them to engage in the assessment and planning of their care. They said discharge was included in care planning from an early stage. Their families and carers were encouraged to be involved in the care planning process. Patients felt their mental health had improved because of the service they received. One patient told us how taking small steps towards his goals had meant his mental health had not relapsed for several years. He described how staff had worked with him to explain the rationale behind the steps so that he understood.

Patients said there were plenty of activities available to meet their individual needs and it was rare that these were cancelled. They said there were opportunities to be involved in service provision and planning, through community meetings, having a ward representative, patients' council and meetings with the management team.

One patient who had reduced mobility stated that he had no issues with the environment and all areas were fully accessible.

Patients stated that there was a choice of food, which they described from "very good" to "not bad". They were able to give feedback about catering every day. Portion control was used to ensure a healthy diet, which patients saw as positive. Some patients were involved in "mission fit", a 12-week health improvement programme designed to increase physical fitness and encourage healthy eating.

Patients told us they had access to spiritual support but one was not aware of the multifaith room on site. One service user would have liked access to a mobile library and more reading material.

Several patients commented on the way the senior staff on their respective wards led their teams and two

Summary of this inspection

patients did not think they were given enough credit for this. Another patient made special reference to a new ward manager who he felt had made a big improvement to the ward.

However, one patient comment card made reference to incidences of bullying and disrespect for each other among patients.

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?

We rated safe as good because:

- there were effective systems to maintain safety and security
- all the wards provided safe, clean environments that were suitable for caring for patients
- there was generous space for activities, visits and quiet areas
- medical equipment was available, accessible and checked regularly
- environmental risk assessments took place regularly and there were action plans to address any issues
- there were enough staff on duty to deliver safe care and support to patients
- there were effective handovers and shift changes
- all staff had a clear understanding of relational security
- staff and patients assessed and managed individual risks together, using recognised tools
- risk assessments were person-centred, proportionate and reviewed regularly, and staff recognised and responded appropriately to changes in risks to patients
- all patients had a physical health assessment and there were a number of health promotion initiatives
- staff carried out therapeutic drug monitoring
- staff were using positive behaviour reinforcement to deal with potentially violent situations
- there was a clear culture of least restrictive practice and positive risk taking
- there were clearly defined and embedded systems to keep people safe and safeguarded from abuse
- staff understood their responsibilities in relation to reporting incidents
- when things went wrong, the provider undertook thorough investigations that involved all relevant staff and people who used the services
- learning from incidents was shared and acted on.

Good



Summary of this inspection

However:

- on Elmhurst ward, there was black mould around the silicone seals in the bathrooms
- patients were only allowed access to the ward garden areas with a member of staff and the door to the garden was locked.

Are services effective?

We rated effective as good because:

- there was a strong recovery focused ethos
- care and treatment achieved good outcomes and promoted a good quality of life
- records showed comprehensive assessments of patients' needs
- staff and patients planned care and treatment together in line with current evidence-based guidance, standards, best practice and legislation
- discharge planning was collaborative and took into account individual needs, circumstances and ongoing care arrangements
- patients had good access to a comprehensive programme of psychological therapies
- there were a number of initiatives to improve physical health and encourage healthy lifestyles
- the continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care
- staff had the skills they needed to carry out their roles effectively. They received regular supervision and learning needs were identified as part of the appraisal and supervision process
- staff recognised the benefit of close working with allied health professionals and care from a range of different disciplines was coordinated. Multidisciplinary meetings worked effectively to coordinate person-centred patient care and there were established positive working relationships with other providers
- adherence to the Mental Health Act and the associated code of practice was good
- staff understood the requirements of the Mental Capacity Act 2005.

However:

- some staff on Kenton ward were not aware of the reflective practice groups.

Good



Summary of this inspection

Are services caring?

We rated caring as outstanding because:

- there was a strong, visible person-centred culture
- staff were responsive, caring and enthusiastic about the patients' care and their progress
- feedback from patients was overwhelmingly positive about the way staff treated people
- relationships between patients, relatives and staff were strong, caring and supportive
- staff and managers valued and promoted positive relationships
- staff respected and valued patients as individuals and empowered them as partners in their care
- staff empowered patients to have a voice and to realise their potential
- putting patients at the centre of the service, involving and empowering them was clearly embedded in the hospital culture
- patients we spoke with felt fully involved in their care planning and review processes and stated they had regular opportunities to have their say in reviews of their care
- there were a number of initiatives to support and improve the patients' experience
- there was a culture of shared decision making and patients were actively involved in all aspects of service development
- patients were supported to maintain and develop their relationships with the people close to them, their social networks and community
- patients were enabled to manage their own health and care whenever possible, and to maintain their independence
- staff actively promoted advance decision making so that all staff could understand how the patient would like to be cared for when they were not well.

Outstanding



Are services responsive?

We rated responsive as outstanding because:

- the service focused on helping patients to be in control of their lives and build their resilience so that they could regain a meaningful life

Outstanding



Summary of this inspection

- there were innovative approaches to providing cohesive person-centred care that involved other service providers, particularly for people with multiple and complex needs
- there was a focus on normalising behaviours and life in the wider community
- patients were enabled to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to
- care pathways were clear and patients' individual needs and preferences were central to the planning and delivery of tailored services
- patients were involved in the design and delivery of services and day-to-day decision-making processes
- there were clear strategies for involving relatives and carers and staff actively sought carers' views about the service
- staff took a proactive approach to understanding patients' diverse needs and deliver care in a way that promoted equality
- staff researched and acquired the skills needed to develop a one-to-one programme of specialist care
- complaints were seen as an opportunity to understand the patient perspective and improve practice
- patients were involved in reviewing complaints via the patients' council.

Are services well-led?

We rated well-led as outstanding because:

- the leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care
- staff described a shared recovery-focused vision
- there was positive leadership at the hospital, and senior staff were very visible and well known to staff and patients
- there was a good governance structure to oversee the operation of the hospital
- governance and performance management arrangements were proactively reviewed and reflected best practice
- there was a strong ethos of innovation that was encouraged and celebrated by managers, staff and patients

Outstanding



Summary of this inspection

- feedback from annual surveys, ward quality matters, and patient-reported outcomes were actively used to inform and prioritise improvements in patient experience and care
- leaders encouraged cooperative, supportive relationships among staff
- staff felt respected, valued and supported, and were positive about their jobs
- there was excellent commitment to quality improvement

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.

All but one of the patients receiving care at Kemple View were detained under the Mental Health Act 1983 (MHA). Adherence to the MHA and associated code of practice was good.

Staff understood the statutory requirements of the MHA. They were aware of the changes to the code of practice in 2015. New policies had been produced to facilitate implementing the changes.

In the patient files we looked at, all statutory detention documentation was in order. All treatment was given under an appropriate legal authority. Second opinion appointed doctor requests had been made where appropriate.

There was an independent mental health advocate (IMHA) who provided support to patients on request.

A Mental Health Act reviewer completed a monitoring visit on Elmhurst ward during this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood and were compliant with the requirements of the Mental Capacity Act 2005 (MCA). They understood the MCA definition of restraint and worked within the least restrictive option principle. They had a good understanding of mental capacity and consent issues.

Mental capacity assessments were only carried out when there were doubts about the patient's mental capacity. This meant that patients received appropriate support to help them make specific decisions.

There was a policy that staff could refer to and the social work team also provided guidance.






There were no patients subject to deprivation of liberty safeguards (DoLS).

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/secure wards	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Overall	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good 

Safe and clean environment

All the wards had spacious communal rooms, activity areas and a kitchen. There was a lounge and separate dining room that patients had access to throughout the day. Patients were able to make their own drinks and snacks whenever they wanted. There were further quiet rooms and visiting rooms. The furniture appeared comfortable, contemporary and in good order.

On each ward, patients had their own bedrooms with en-suite toilet and washbasin. The bedrooms were spacious and had a lockable space for personal items. There were nurse call alarms next to each bed. Additional showers and bathrooms were available.

All the areas we inspected were clean and well maintained. The cleaning records were complete and up-to-date. Staff explained the infection control procedures they followed.

However, on Elmhurst ward, although the bathrooms and shower facilities were cleaned regularly, there was black mould around the silicone seals.

The clinic areas were clean, tidy and well organised. Drugs cupboards, trolleys and fridges were tidy and in good order. We checked all equipment including resuscitation equipment and emergency drugs and found it was in good order and in date. Fridge temperatures were checked daily and the records were all up-to-date.

During the visit, we checked the ward “grab bags” and the contents were all present and in-date. We also checked the emergency first aid bags and found the contents were present and in-date.

The GP suite adjacent to Arkwright ward had a fully equipped examination area. Patients who needed to be examined either went to the GP suite or were visited on the ward by the practice nurses.

There were blind spots and ligature points on all the wards. A ligature point is anything that could be used by a patient to self harm. The hospital had undertaken a ligature audit on the wards that set out how the risks were mitigated through using mirrors, observation, staff awareness, care planning, including clinical risk assessment and individual levels of observation and good relational security. These risks were reviewed every month. The staff we spoke with on each ward were aware of the risks on their ward and explained how they were managed.

To help mitigate risks, some wards had CCTV fitted in the communal areas and others were awaiting installation, which was under way during the inspection. Patients and staff had been consulted and there was general consensus this was a positive move.

The ward areas and clinics were secure. All non-communal areas were locked.

Staff, patients and visitors entered and left the wards via an airlock. The door access system operated in conjunction with a key tracker system that blocked the exit if a key holder tried to leave before returning their keys. All staff were familiar with the safe management of keys and were



Forensic inpatient/secure wards

aware of the appropriate policies and procedures in respect of security. New staff completed a security induction before they were given keys and all staff underwent annual security training.

Two of the wards, Arkwright and Wainwright, had seclusion facilities. The seclusion rooms met all the requirements of the Mental Health Act 1983 code of practice. Both had access to integrated bathroom facilities. The rooms had controllable blinds on the windows and the lighting and temperature control was located outside the rooms. Patients had sight of a clock outside the room.

Each ward had a designated security nurse on each shift to oversee access, security and safety. All staff were able to tell us what needed to be checked to maintain the physical security and safety of their ward.

All the staff we spoke with at all levels had a clear understanding of relational security. They were aware of the significance of building trust, setting and maintaining boundaries and understanding the patient group dynamic. Good relational security enables a balance between restrictive practice and a caring environment. Staff explained how they implemented “see think act” in their day to day work. “See think act” is a Department of Health guide to relational security. It looks at four main areas of relational security and risks to patient care so that staff understand what they can do to keep patients safe and provide high quality care. The guide includes a relational security explorer, a tool staff can use to look at how relational security can be improved on their ward. “See think act” was well embedded.

Staff used personal alarms to call for assistance from staff on other wards if there was an emergency. There were designated staff on each shift who responded to incidents on other wards.

The outside recreation areas of the wards were kept locked. These areas were secure so the reason for preventing all patients going outside was unclear. Patients who had appropriate leave could also access other garden areas on the site.

The wards had a designated health and safety representative, supported by a qualified full-time staff member responsible for all health and safety issues.

Safe staffing

Each ward had the following full time equivalent staff in post:

Arkwright

- 1 ward manager
- 1.9 charge nurses
- 5.8 staff nurses
- 15.5 health care support workers

Elmhurst

- 1 ward manager
- 2 charge nurses
- 10.2 staff nurses
- 17.6 health care support workers

Kenton

- 1 ward manager
- 2 charge nurses
- 6.7 staff nurses
- 12.6 health care support workers

Wainwright

- 1 ward manager
- 2 charge nurses
- 7.9 staff nurses
- 17.1 health care support workers

Managers planned and reviewed the staffing skill mix to ensure patients received safe care and treatment. They used a safe staffing model developed in line with Compassion in Practice (NHS commissioning board 2012). The base staffing calculation involved consideration of the number of patients, the level of care they required and the resources needed to provide that care. Any staff shortages were responded to quickly and adequately. Staffing levels and the skill mix within the teams meant the staff on duty were able to meet patients’ needs. Staff told us there were sufficient numbers of staff to deliver the care and support that patients needed. Staffing operated via a two-shift system. There were effective handovers to ensure staff understood and could manage risks to patients.

There were no current vacancies or sickness affecting staffing levels. Staff turnover during the 12 months ending on 31 August 2015 was 19.4% and staff sickness was 4%. Where sickness and short term absences needed to be covered, staff were able to provide cover using a bank system. In the three months to 31 August 2015, 396 of 432 shifts requiring cover had been filled. Managers had



Forensic inpatient/secure wards

planned for vacancies and longer absences and cover was arranged. None of the patients and family members we spoke with reported that they had experienced any cancelled activities, leave or appointments. Some patients told us that that section 17 escorted leave had occasionally been postponed due to staffing shortages but never cancelled.

Patients had prompt access to a psychiatrist when they needed one. There was sufficient medical cover during the day and night. Ward rounds for each consultant took place every week and five patients were seen each week, so every patient was seen monthly. However, this was adjusted when patients were more unwell and they were seen more often. A doctor attended in an emergency and was available on call out of hours. Doctors were required to attend within one hour of being called. Consultants provided on call support for one week out of four.

Staff received up-to-date training in all safety systems. The hospital provided a programme of mandatory training for staff that included:

- basic life support
- infection control
- fire safety
- health and safety
- medicines management
- conflict resolution
- managing violence and aggression
- safeguarding
- security
- the Mental Capacity Act
- the Mental Health Act
- information governance.

Managers monitored compliance with mandatory training via an electronic system that alerted managers when refresher training was due. Staff compliance with mandatory training requirements at 30 September 2015 was 87% across the hospital.

Staff induction included training on relational security.

Training had recently been made available via iLearn, an e-learning system that staff could access individually on- or off-site. Staff could view their own mandatory training records with expiry dates flagged and highlighted. They could book onto classroom sessions or complete interactive e-learning courses followed by an e-assessment to ensure their competence. There was also a five stage

audit that randomly checked staffs' knowledge of various topics, for example, safeguarding. A progress bar meant they could monitor their own level of compliance and ensure they remained up to date. Staff had protected time for completing mandatory training.

Assessing and managing risk to patients and staff

Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenged. Patients were involved in managing risks and risk assessments were person-centred, proportionate and reviewed regularly. Staff recognised and responded appropriately to changes to risks in patients.

We looked at the risk assessments for 22 patients. All the records were complete and up to date.

Staff were using recognised tools to assess and monitor risk. A pre-admission needs assessment was completed by the multidisciplinary team (MDT), followed by a post-assessment discussion about whether to accept a patient. A detailed 72 hour care plan was completed on admission and adjusted during the first three months. The historical clinical risk management-20 (HCR-20) and short-term assessment of risk and treatability (START) risk assessment tools were completed during the first three months of admission.

The HCR-20 tool assesses the patient's risk of violence in the present and future.

The START tool measures the patient's own perception of their strengths and vulnerabilities. The assessment was carried out between each patient and clinical team twice a year. The scores measured the patients progress. Patients' own perception of their strengths and vulnerabilities, which rises as they gain insight into their mental health, is expected to increase as their treatment progresses.

Staff assessed and managed individual risks on a continuing basis. Risk assessments were comprehensive and recorded appropriately. Observation levels were clearly recorded. The records also contained the Waterlow pressure ulcer risk assessment, the malnutrition universal screening tool, the Liverpool University neuroleptic side effect rating scale and body maps.

Physical health assessments were carried out on admission by the practice nurses. Full physical healthcare checks had been completed in the past 12 months and where one



Forensic inpatient/secure wards

patient had consistently refused to have the healthcare check, this had been documented fully. There was a service level agreement with a local GP surgery to provide a weekly clinic for patients and the hospital employed two full time practice nurses to provide physical healthcare.

The practice nurses carried out therapeutic drug monitoring for patients prescribed medicines such as clozapine, to ensure their physical wellbeing. They also ensured patients had full written information before commencing the medication.

Staff received training in de-escalation and management of violence and aggression techniques. They were using “reinforce appropriate, implode disruptive” (RAID) techniques that used positive behaviour reinforcement to deal with potentially violent situations. RAID involved all staff including housekeepers and other ancillary staff. Both staff and patients told us that they believed that this approach was having a positive effect on incidents occurring. In the last 12 months there had only been one serious incident recorded that involved violence. RAID training is accredited by the association for psychological therapies.

In the six months up to 31 August 2015, there had been 107 incidences of restraint across three of the four wards. Two incidences involved the use of face down or prone restraint. Eighty of the incidents of restraint occurred on Arkwright and involved four patients.

During the same time period, there had been 12 incidences of seclusion across the same three wards. Seclusion records were completed in accordance with the Mental Health Act 1983 (MHA) code of practice. Patients in seclusion were routinely assessed and the need for continued seclusion reviewed in line with the hospital policy and the code of practice. The records documented why the patient remained in seclusion and their response to staff trying to engage with them. The use of seclusion was also reviewed at the daily morning handover meeting.

Patients had access to their rooms at all times except between 9.00am and 11.00am when the rooms were being cleaned. Many patients had ground or community leave and were utilising this during our visit. There was a clear culture of positive risk taking in the care being given and a range of “real work” opportunities were available, both on-site and in the community.

All the wards operated some restrictive practices that applied to all patients. For example, patients kept their own cigarettes but staff held their lighters or matches. It was recognised that some restrictive practices were necessary for environmental security and patient safety purposes. The service was operating in accordance with company policies. There was a “least restrictive practice” champion on each ward who was responsible for offering advice and support to other staff and disseminating information.

However, some practices were disproportionately restrictive and were not based on individual risk. For example, the wards had enclosed garden areas but patients were only allowed access to the garden areas with a member of staff and the door to the garden was locked. The reason for this was not clear as the gardens were secure within the wards. Patients could ask for additional access to the garden areas and this was then subject to individual risk assessment by the MDT.

Least restrictive practice and a culture of positive risk taking was apparent in the care being provided. Least restrictive practice means that any restrictions should be the minimum necessary to safely provide the care or treatment needed and considering whether this can be achieved in a way that is less restrictive of the patient's rights and freedom of action. Positive risk-taking is balancing the potential benefits and harms of exercising one choice of action over another. This means identifying the potential risks involved, and developing plans and actions that reflect the patient's positive potentials and their own priorities. Many patients had ground or community leave and were utilising this during our visit. Patients had access to their rooms at all times except between 9.00am and 11.00am when the rooms were being cleaned.

Patients' access to personal mobile phones was risk assessed by the MDT and included in care plans. Patients were required to hand their personal mobile phones to staff at 10.00pm each day although they could request unrestricted access to their mobile phones. This would be individually risk assessed by the MDT, taking account of the patient's mental state and any history of nuisance calls.

Care plans included allowing staff to monitor usage of the phones when patients handed them in. All mobile phones were subject to random checks and compliance with the individual patient's mobile phone contract.



Forensic inpatient/secure wards

Efforts had been made to relax restrictions in some areas. Instead of searching all patients every time they returned from leave, staff were using technology so that patients to be searched were selected at random.

There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse. Safeguarding arrangements took account of both adult and child safeguarding. Staff received mandatory training in safeguarding at level one. We discussed safeguarding with staff. They showed good understanding of safeguarding issues and explained how to make a safeguarding alert. There were good links with the local safeguarding authority. Safeguarding information was displayed in the wards. A safeguarding policy and procedures were available for staff guidance. Social workers also provided guidance. We saw evidence that staff recorded and reported safeguarding incidents appropriately.

There were policies and procedures covering all aspects of medicines management. Staff were trained in medicines management and had a good understanding of safe medicines management. Staff explained how to report a medicines incident.

Qualified staff carried out a medicines audit every weekend looking at prescription charts including checking that appropriate authority to treat had been obtained, ensuring medicine stocks were accurate and in date, and checks of the clinic room and equipment including emergency equipment. This had highlighted incidences where staff had omitted to sign prescription charts confirming whether or not medicines had been administered. We saw evidence of how this had been addressed and a piece of reflective work carried out to consider how such incidents could be avoided in future.

There was a policy that set out arrangements for child visitors. There was a designated room away from the ward areas where children could visit.

Track record on safety

Staff were encouraged to report all incidents. They had reported five serious incidents in the 12 months up to 30 September 2015 (although none had occurred in the last six months). These comprised one violent incident, two injuries following falls, one patient's death and one security compromise. All the incidents had been investigated. We

saw instances of learning following investigation of these incidents, for example, a detailed protocol and supporting documents setting out the management of falls that had been communicated to all staff.

Reporting incidents and learning from when things go wrong

There was an electronic incident reporting system. This enabled ward managers and senior managers to review and grade the severity of incidents. All staff took responsibility for reporting and had access to the reporting system.

Openness and transparency about safety was encouraged. Staff explained how to report an incident. They understood their responsibilities in relation to reporting and told us they felt supported in doing so. Managers analysed adverse events to identify any trends and they took appropriate action in response. The senior management team and all ward managers attended a daily morning meeting where they discussed all reported incidents and the action to take. Ward managers fed back to their teams. This meant staff understood risks and gave a clear, accurate and current picture of safety.

When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and patients.

Staff and patients were de-briefed and supported following serious incidents. De-briefing incorporated support and reflective discussion. It included input from a psychologist. The staff we met with reported feeling well supported by managers and their colleagues. They described an embedded open and supportive culture. Patients also told us they felt well supported.

Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. Opportunities to learn from external safety events were also identified. Recommendations and learning from incidents was shared via service-wide communications such as a "lessons learned" newsletter and discussed at weekly business meetings and team briefing sessions. Lessons learned at other of the provider's locations were also shared. Managers discussed learning and actions in team meetings and one-to-one supervision to ensure lessons were learnt. We saw meeting notes confirming this.



Forensic inpatient/secure wards

Improvements to safety were made and the resulting changes monitored. We saw documentary evidence that the service learned from incidents and made improvements. For example, an incident involving aggressive behaviour had been reviewed and practice amended as a result so that patients were kept safe. We saw evidence that staff had reflected on what had happened and how it could be avoided in the future.

There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences. We found a culture of collective responsibility across the service and one where the benefit of raising concerns was valued. We saw that issues raised were investigated in a sensitive and confidential manner, and lessons were shared and acted upon.

Duty of Candour

Across the wards, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good



Assessment of needs and planning of care

There was a strong recovery focused ethos and holistic approach to planning care. There was a recovery champion on each ward who was responsible for offering advice and support to other staff and disseminating information.

We examined 22 care records. We found them comprehensive, showing evidence of individual diverse needs and patient involvement in developing them. Staff and patients together re-evaluated and updated care plans following changes to care needs.

The care programme approach (CPA) process focused on recovery aspects such as relapse prevention, early warning signs, support networks and self-harm reduction.

Pre-admission assessments were carried out by the multidisciplinary team (MDT). A detailed 72 hour care plan was completed on admission and adjusted during the first three months.

Consultants saw new patients on a weekly basis and all patients had a CPA meeting within three months of admission.

Staff carried out an initial assessment that incorporated mental and physical health assessments and further health investigations where necessary. It included a risk assessment and evaluation of patients' social, cultural, physical and psychological needs and preferences. The assessments focused on patients' strengths, self-awareness and support systems, in line with recovery approaches. There were clear care pathways and structure for care. Care records we looked at confirmed that staff assessed patients when they were admitted and made plans for their continuing support from the start of their treatment.

With the patient, staff developed a care plan during the first three months of admission. The records we reviewed were up to date. The care plans were centred on the patient's needs as identified by themselves. They were recovery focused and showed knowledge of current, evidence-based practice. There was evidence of good MDT working and referral to other services such as an external falls team, based on the patient's needs.

Managers carried out audits of care records that included checking risk assessments, care plans, physical health care and whether service users had been given copies of their care plans. All were complete and up to date.

Patients told us that care planning was progressive and goal-led. They confirmed that they had regular sessions with their primary nurse to discuss and review their care plans, and that they attended review meetings with the MDT. Any agreed changes in care and treatment were entered on the electronic care notes system. The records were projected onto a screen so that the changes were visible as they were made. Families and carers were encouraged to be involved in the care planning process.

The systems to manage and share the information needed to deliver effective care were fully integrated. Records were stored electronically and access was protected. Some records, such as Mental Health Act documents, "recovery



Forensic inpatient/secure wards

star” records and Liverpool University neuroleptic side effect rating scales, were kept in a paper format. These too were stored securely and staff had access to them so that all information they needed was readily available.

Best practice in treatment and care

Staff planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Staff on all the wards implemented evidence-based guidance within their clinical practice, for example, in line with the National Institute for Health and Care Excellence (NICE) and Department of Health guidelines relating to risk management, aggression and violence and schizophrenia. Care plans also referenced national guidance.

There was a team of psychologists who had developed comprehensive treatment programmes encompassing dialectical behaviour therapy, which is designed to change patterns of behaviour such as self harm, suicidal thinking and substance misuse by learning about the triggers that lead to such reactive states and help to develop coping skills. Some programmes took place in groups but most of the work was undertaken in 1:1 personalised programmes.

Many patients were engaged in psychological therapies. They could self refer or the multi disciplinary team (MDT) could make a referral. Staff described a range of interventions they used to support patients in their recovery, including mindfulness, a sexual behaviour modification programme, with enhanced response for those with cognitive disorder, “future focus” group, “responsible living” group and “reinforce appropriate, implode disruptive” (RAID). RAID uses positive behaviour reinforcement to deal with potentially violent situations. On Arkwright ward, there was a reminiscence programme.

We reviewed supervision records and they confirmed staff were using NICE guidelines, for example, in relation to risk management.

Patients’ physical health needs were considered alongside their mental health needs. The care records we reviewed included full physical healthcare checks.

Two full-time practice nurses were responsible for physical healthcare across the site. They carried out a full physical health check that included a routine electrocardiogram within 24 hours of admission and every year afterwards. This was monitored via an electronic quality dashboard.

The records we looked at all contained records of full physical healthcare checks that had been completed in the past 12 months. Where one patient had consistently refused to have the healthcare check, this had been documented fully. There was a service level agreement with a local GP surgery to provide a weekly clinic that included monitoring of chronic illness. Patients who had appropriate leave could also visit the GP surgery in the community and the practice nurses would arrange appointments for them. Patients also had access to physiotherapy, chiropody and an optician, all of whom visited on a regular basis.

Staff used clinical tools to audit the effectiveness of interventions. They were using nationally recognised assessment tools, such as the historical clinical risk management-20, the short-term assessment of risk and treatability and the Health of the Nation Outcome Scales. The Liverpool University neuroleptic side effect rating scale was being used to monitor the side effects of medication. Some patients were using the “recovery star” and “my shared pathway” to measure their progress. Information about effectiveness was shared, for example, via MDT and governance meetings and reports published internally and externally, and used to improve care and treatment and patients’ outcomes.

Staff monitored nutrition and hydration using the malnutrition universal screening tool.

High performance was recognised by credible external bodies. The low secure service had been reviewed by the Royal College of Psychiatrists’ quality network review team in April 2015 and fully met 95% of low secure standards, compared with a benchmark of 81%. As part of the self review stage, patients were invited to take part in a telephone conference. Following the peer review stage, suggested actions had been addressed, for example, patients were asked to complete daily food feedback forms. Patient involvement and the use of projectors during CPA meetings ensured patients had the opportunity to comment on the report.

Kemple View was recognised as a RAID centre of excellence. RAID is a recognised industry standard method of working with patients to help them manage their own behaviour, accredited by the association for psychological therapies.



Forensic inpatient/secure wards

Being recognised as a RAID Centre of Excellence means that the organisation is implementing RAID principles outstandingly well, using a positive approach to interventions.

Additionally, Arkwright and Wainwright wards were recipients of the 2015 RAID awards for working with challenging behaviour. Judges' comments included "demonstrates the all-important empathic understanding of a person with challenging behaviour", "a good clear exposition of the RAID approach", "good to see RAID champions, RAID care plans, RAID ladders being used, RAID posters, and RAID meetings" and "a thoroughgoing application of RAID." This status is re-appraised at least every two years to ensure its current validity.

Two members of staff had won provider's regional awards, one for their work in dementia awareness and the other for their work on the woodland walk and for introducing colour around the site.

Staff took part in clinical audit, for example, the NHS benchmarking audit of restraint, the national audit of schizophrenia and national prescribing observatory for mental health (POMH-UK) topics.

The service used the commissioning for quality and innovation framework as quality indicators. Currently these included involving patients in formulating and updating risk assessments and implementing quality dashboards. There were clear timescales and action plans that were regularly reviewed.

Skilled staff to deliver care

Patients had access to a range of mental health disciplines to aid their recovery. There was an effective multidisciplinary structure that included input from mental health nurses, support workers, social workers, occupational therapists, psychologists, administrative support and doctors.

There was a strong focus on continuous learning and improvement, and opportunities for learning and sharing across the service. We found examples of good or excellent practice in all the wards. Safe innovation was supported. Staff were encouraged to take time out to review performance and make improvements.

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire

new skills and share best practice. The training records we saw showed that staff had accessed a range of training so they were able to meet patients' needs. We saw discussion about additional training noted in supervision records and managers encouraged staff to develop skills in specialist areas. Staff had undertaken training in dialectic behaviour therapy, end of life care, suicide prevention, research and leadership training. Following leadership training, staff were encouraged to develop a piece of innovative work to implement on their ward. One member of staff had developed a support programme for staff escorting patients on leave.

There were many opportunities for learning and development such as external university courses. Some nurses had previously been health care support workers and the company had supported them through university in order to become registered nurses. Other disciplines also said that the company had paid for and supported them to gain further qualifications in order to improve patient care. There were also reciprocal arrangements with local organisations for specialist training, for example, around substance misuse.

New staff underwent a comprehensive induction that incorporated the care certificate for non-registered clinical staff. The care certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It sets out national standards that underpin the skills, knowledge and behaviours needed to ensure staff provide compassionate and high quality care and support.

Staff were supported to deliver effective care by means of supervision and appraisal of their work performance, to identify additional training requirements and manage performance. Staff had an annual appraisal that included setting objectives for personal development. The appraisal records we saw confirmed this. All staff had had an appraisal in the last 12 months.

Staff received clinical and managerial supervision every month. The organisation's values were linked to supervision and appraisal. Supervision records included discussion of appraisal objectives, NICE guidelines, training needs and patient engagement. Staff well being was also discussed. They said they found supervision invaluable. The 12 records we reviewed were all up to date.



Forensic inpatient/secure wards

Every member of staff had a supervision “passport” in which they recorded all types of supervision. This included group supervision, reflective learning and informal discussions as well as formal sessions with their supervisor.

There were opportunities for staff to improve their practice, for example, case formulation and reflective practice groups were available for all staff at each ward. Most of the staff we spoke with said they found discussion of challenging clinical issues invaluable in exploring ways to improve the service they provided. However, some staff on Kenton ward were not aware of these groups. This was a concern given the nature of the challenging work carried out on this ward.

Staff and managers discussed performance in one-to-one supervision sessions. We saw evidence of this in the records we looked at. Managers explained the process they followed and told us they felt well supported in dealing with poor performance. During the inspection, we saw how poor performance or mistakes were managed.

Multidisciplinary and inter-agency team work

Staff recognised the benefit of close working with allied professionals and care from a range of different disciplines was coordinated. The MDT was well integrated and collaborative working was embedded. All relevant staff, teams and services were involved in assessing, planning and delivering people’s care and treatment. Staff worked together to understand and meet the range and complexity of people’s needs. They provided a range of therapeutic interventions to support patients’ recovery in line with best practice guidance.

Each ward held weekly multidisciplinary team (MDT) meetings to review the mental health of the patients. Health care support staff did not attend routinely but made a request if they wished to attend.

We observed two MDT meetings. The MDT worked closely to plan patients’ care and treatment in a holistic way. Discussion was factual, sensitive and patient focused. The care and concern shown for each patient was evident. The independent mental health advocate (IMHA) attended and their view was sought in the progression of care. There was frank, open and respectful discussion with the patients. In light of risk evidence, the MDT explored fresh options to rebuild levels of trust and increase levels of patient responsibility. They took great care in seeking the patients’

views and opinions to ensure they were involved in developing the plan. There was clear commitment to working collaboratively to provide the best possible care for patients.

There were handover meetings twice daily on each ward, at every shift change. Every morning, senior staff and senior managers met to review issues such as referrals, admissions, discharges and transfers, incidents reported, observation levels, risks, safeguarding and complaints. We attended one of these meetings and found it to be well structured, informative and productive.

We reviewed minutes of business meetings that took place every month. Discussion included such issues as team performance, training, safeguarding, safety alerts and communications, outcomes measurement and the duty of candour.

There were established positive working relationships with other service providers such as GPs and community services and groups where patients could undertake voluntary and vocational work placements.

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

Where people were subject to the Mental Health Act 1983 (MHA), their rights were protected and staff complied with the MHA code of practice.

Training in the use of the Mental Health Act 1983 (MHA) was mandatory and 98% of staff were up to date. They had a good understanding of the application of the MHA and its guiding principles. We were assured by talking with staff that they understood how patients were assessed, cared for and treated in line with the MHA and the associated code of practice. Staff understood the statutory requirements of the MHA. Staff were aware of the changes to the code of practice in 2015. Since April 2015, new policies had been produced to facilitate implementing the changes. There was a “least restrictive practice” champion on each ward who was responsible for offering advice and support to other staff and disseminating information.

During this inspection a Mental Health Act reviewer completed a monitoring visit on Elmhurst ward.

All patients receiving low secure care were detained under the Mental Health Act 1983 (MHA). Adherence to the MHA and associated code of practice was good.



Forensic inpatient/secure wards

We looked at four patients' files. All the statutory detention documentation was in order. The procedures for renewal of detention had been followed and there was evidence that the criteria for renewal had been met. Patients' rights under section 132 were revisited regularly and the patients we spoke with understood their rights under the MHA.

They were aware of their right to appeal to the mental health review tribunal (MHRT) and/or the hospital managers and we saw evidence in patient files that some had exercised this right of appeal. We also saw that when necessary, referrals had been made by the hospital to the MHRT. Hospital manager's decisions were clearly and appropriately recorded and the patients were informed of the decisions in line with the MHA Code of Practice.

Patients were able to take leave of absence as authorised by the responsible clinician or by the Ministry of Justice where required. Patients were given a copy of their leave form and the leave was authorised through a standardised system. Only the current leave form was contained in the patient files. Risk assessments were completed before the leave was authorised and on return a record of how the leave went and the patient view of how it went it was recorded in the patient notes.

All treatment was given under an appropriate legal authority and T2 and T3 certificates were in place. Section 61 documentation was also evident for those on T3s when required. We saw evidence that the responsible clinician had made a note of the patient's capacity to consent to treatment at the most recent authorisation. Second opinion appointed doctor (SOAD) requests had been made where appropriate.

There was an independent mental health advocate (IMHA) who supported patients on request. The IMHA visited the ward each week to ensure patients were aware of the support that the IMHA could provide.

Some patients told us that that section 17 escorted leave had occasionally been postponed due to staffing shortages but never cancelled.

Good practice in applying the Mental Capacity Act

Ninety eight per cent of staff had completed Mental Capacity Act training in the 12 months up to 11 September 2015. The staff understood and were compliant with the requirements of the Mental Capacity Act 2005 (MCA). Staff we spoke with understood that capacity fluctuated and

that patients may have capacity to consent to some things but not others; for example, to be able to pay for shopping but not for more complex financial matters. There was a policy that staff could refer to and the social work team also provided guidance.

Staff took steps to support patients to make decisions about their care and treatment wherever possible. There was good understanding of mental capacity and consent issues. Consent to care and treatment is obtained in line with the MCA. We saw evidence that the responsible clinician had made a note of the patient's capacity to consent to treatment where this was appropriate. All patients had preferred priority care plans that contained advance decisions, for example, around how restraint would be used should it become necessary. Staff understood the MCA definition of restraint and worked within the least restrictive option principle.

Staff understood the process to follow if a decision was needed about or on behalf of a person lacking mental capacity to consent to proposed interventions. It was clear from our discussions with staff and the care records we reviewed that staff worked from the premise that patients had mental capacity. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded, showing a clear process. Mental capacity assessments were only carried out when there were doubts about the patient's mental capacity. This meant that patients received appropriate support to help them make specific decisions.

There were no patients subject to deprivation of liberty safeguards (DoLS).

Are forensic inpatient/secure wards caring?

Outstanding



Kindness, dignity, respect and support

Patients were respected and valued as individuals and empowered as partners in their care.



Forensic inpatient/secure wards

Feedback from patients and the people close to them was always positive about the way staff treated them. Patients and those close to them told us that the care they received was exceptional and that staff went out of their way to provide high quality care.

There was good engagement between staff and patients on all the wards. Staff treated patients with dignity, respect and kindness during their interactions and the relationships between them were positive. Patients told us they felt supported and said staff cared about them. They described staff as friendly, approachable and helpful. We saw the staff knocked on bedroom doors before entering and patients confirmed this was usual practice.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients, the people close to them and staff were caring and supportive. These relationships were highly valued by staff and promoted by leaders both at ward level and by the senior management team.

Staff recognised and respected the totality of patients' needs. We saw evidence in care records that patients' personal, cultural, social and religious needs were considered.

The staff ensured patients' dignity, privacy and confidentiality was always respected.

The practice nurses said patients would call to see them if they had a problem they did not wish other patients to become aware of and cited examples where discreet arrangements had been put in place.

The involvement of people in the care they receive

At the beginning of the inspection, patients, staff and the hospital director presented an overview of the service with their achievements and plans for the future. A representative of the patients' council took a lead role in this. Putting patients at the centre of the service and involving and empowering them was clearly embedded in the hospital culture. The clear commitment to genuine patient involvement was exceptional.

The wards operated a scheme whereby new patients were allocated a 'buddy' to help orientate and welcome them to the ward. The patients had designed a welcome booklet with information about the ward and service.

Staff respected and valued patients as individuals and empowered them as partners in their care. Their individual preferences and needs were always reflected in how care was delivered. Patients and staff worked together to plan care. We saw staff spending time talking with patients. They communicated with them in ways that they could understand. Patients told us they understood their care, treatment and condition. They were involved in influencing their care and treatment or the service at the hospital in a number of ways, including planning for their discharge.

For example, patients contributed to their own care records. We saw examples of care plans showing evidence of patients' views and involvement in developing them. Family, friends and advocates were involved in care if the patient wished. Patients all had a copy of their care plan and where they did not, the reason for this was documented.

Patients completed reflective diaries each day, with staff or on their own, and added their own notes to their care records.

We observed two multidisciplinary meetings at which patients were involved and consulted. Patients also had the opportunity to chair their own care programme approach meetings and choose who should be invited, including their family members if they wished. Staff and patients discussed progress, risk management and care planning together. They reviewed care plans and risk assessments during the meeting. This meant there was plenty of opportunity for discussion and agreement with patients and staff. Changes were entered directly into the electronic notes and a projector was used so that everyone in the meeting could see the record. This ensured patients had the opportunity to comment on the report as it was written.

Staff were fully committed to working in partnership with patients and making this a reality for each patient. Staff empowered patients to have a voice and to realise their potential.

Each ward held weekly community meetings. Patients had the opportunity to chair the ward community meetings. These meetings engaged patients and improved communication on the wards. We saw minutes of some of these meetings that documented discussion about issues patients raised.



Forensic inpatient/secure wards

There were regular patient surveys. Action plans for improvements were developed from the findings. We saw that a patient led review of the “real work opportunities” programme was scheduled to take place in early 2016.

Patients had opportunities to get involved in hospital governance, for example, via the patients’ council. Each ward had patient representatives who sat on the patients’ council. The patients’ council meetings were chaired by patients, with support from the hospital director, and attended by all heads of departments. Part of the patient representative role was to take information from matters discussed at the council back to their peers on the wards. They would also take matters to the council that were raised by fellow patients for discussion and consideration if those matters could not be resolved at ward level through the community meeting. The patients’ council had a strong voice and was represented at governance meetings, where they were involved in discussion and decisions about matters such as funding, service issues and developments. We saw meeting minutes that clearly confirmed the respect given to patients’ views and opinions.

Patients were supported to maintain and develop their relationships with the people close to them, their social networks and community. They were helped to manage their own health and care whenever possible, and to maintain their independence. Some patients had the opportunity to self-cater and many had access to an extensive range of paid “real work” opportunities, both on-site and in the community. Patients applied and were interviewed for these posts and received reimbursement for the work they carried out. On-site, opportunities included sitting on interview panels for staff recruitment and being involved in staff induction and training. Patients received training to support them to do this effectively. Other opportunities included working in the on-site café, which involved ordering supplies, choosing healthy options, preparing food and sales. Patients also ran a lunch club every week. Off-site opportunities included gardening and work in local businesses. Patients and staff were positive about the programme, which they viewed as a real experience of work that was recovery focused.

One patient had won the national 2014 outstanding service user achievement award for his project “My shared

pathway additions and adaptations in an aging population”, and in the same awards, Kemple View patients’ allotments project won a commendation in the community/vocational initiative category.

Staff offered support to patients’ families and friends. There was a quarterly carers’ meeting and visitors were offered assistance with transport where they needed it in order to be able to visit their relatives. This meant patients were able to maintain their relationships with the people close to them.

There was excellent support for patients and their families in the use of technology. Skype facilities were available so that patients could more easily maintain their relationships with the people close to them, particularly where there was significant distance. As well as assisting patients, the service had invested time in familiarising patients’ friends and families with the use of Skype.

There was an independent mental health advocate (IMHA) who supported patients. Patients had direct access to advocacy services and there was information displayed across all the wards. The IMHA also visited the wards each week to ensure that patients were aware of the support that the IMHA could provide.

All patients had preferred priority care plans that contained advance decisions, for example, around how restraint would be used should it become necessary.

Are forensic inpatient/secure wards responsive to people’s needs? (for example, to feedback?)

Outstanding



Access and discharge

Care pathways and admissions could be from high secure units, medium secure units, prison, courts or other inpatient units. Admissions to the hospital were planned. The multidisciplinary team completed the pre-admission assessment. Senior staff made a decision regarding admission at the morning handover meeting.

Patients were placed from various parts of the UK due to placements that would meet their needs not always being available in their home area.



Forensic inpatient/secure wards

In the six months prior to this inspection, average bed occupancy for all four wards was over 97%.

The service worked within the principles of the recovery model. This meant they focused on helping patients to be in control of their lives and building their resilience so that they could regain a meaningful life. This helped to reduce the risk of patients relapsing during their recovery. This meant that staff ensured patients did not stay in hospital longer than necessary and promoted patients' early discharge. In the period from 01 February to 31 August 2015, four patients had delayed discharges across two wards. Managers told us this was due to aftercare and funding arrangements, which the patients' home area services had responsibility for. Alternatively, other specialist placements were sought.

We saw evidence of planning for discharge, transfer or transition to other services, including potential future placements, which began at the earliest possible stage. Discharge plans were included in care planning. All the patients and carers we spoke with were aware of plans for discharge. Discharge arrangements were considered from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. This included providing support to patients during periods of leave.

Care and treatment was coordinated with other services and other providers. Staff worked closely with care coordinators to ensure that patients were helped through their discharge. Staff told us that external care coordinators sometimes found it difficult to attend care programme approach (CPA) meetings; however, this was beyond the control of the service. Tele- and video-conferencing was used to facilitate input. Discharges or transfers were discussed in the multidisciplinary team (MDT) meeting and were managed in a planned and coordinated way. There was a care pathway from low secure to locked rehabilitation wards depending on individual needs. Staff worked closely with commissioners to facilitate transfers and discharges.

The facilities promote recovery, comfort, dignity and confidentiality

The ward facilities and premises were suitable to promote recovery and support care and treatment. Clinic rooms were clean and well equipped. There were rooms where patients could relax and watch TV or engage in therapeutic activities. These included quiet areas, activity and meeting

rooms and sports areas. Some rooms could double as quiet areas or therapy spaces. Each ward had a room where patients could meet visitors. These were away from the main ward area and afforded privacy for patients and their visitors. There was a separate room away from the wards for visits with children. Patients had access to a private telephone cubicle. The independent mental health advocate could be contacted by pressing one button on the phone. Patients had access to the internet via a computer on the ward and the hospital had recently installed Skype so that patients were able to maintain contact with their families. Some patients had the opportunity to self cater.

Many patients had access to a range of "real work" opportunities, both on-site and in the community. The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patients' needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs. Patients were supported to attend community groups and activities; for example, neighbourhood groups, learning, vocational or volunteer opportunities. This helped patients to take part in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to. Social inclusion is closely linked with recovery. Services have a key role in supporting patients to take part in mainstream activities.

Secure garden areas within the wards provided access to outside space, although this was subject to restrictions, and included a smoking area. The hospital grounds were spacious with gardens, a woodland walk and seating areas.

Drinks and snacks were available on the wards. There were rehabilitation kitchens that were open all day and locked at 12 midnight. A small drinks area was available to use at any time. Patients could practice and develop daily living skills, such as cooking, shopping, budgeting and washing laundry.

Staff encouraged patients to personalise their bedrooms. The bedrooms we viewed had been arranged with care by the patients, with pictures, books, personal effects, music system etc. Bedrooms on Arkwright had "memory boxes" attached to the wall by the door. These contained memorabilia and photographs personal to the patient.



Forensic inpatient/secure wards

Each room had a locker where patients could store personal property securely.

Activities were offered seven days a week although some ward based activities were described as “low key”, such as board games. There was a large sports hall that was also used for social events such as cinema nights. Within the grounds there was an art room, music room, IT suite, education facilities, on site café, a large horticulture area and animals. Other activities included swimming, cycling, boxercise, a gym, smoking cessation and mindfulness groups. Activity focused on promoting recovery and developing skills to maintain independence. Patients were encouraged to use community facilities wherever possible, reflecting the focus on normalising behaviours and life in the wider community. Leave authorised under section 17 Mental Health Act 1983 was well structured, which meant that patients could access a range of activities.

There were several initiatives to improve physical health and encourage healthy lifestyles.

A series of 12-week programmes called “mission fit” were under way during our inspection. The programme incorporated education about healthy living as well as taking part in exercise sessions. It was run by a qualified fitness instructor, using visual aids and actual examples to ensure learning for patients was appropriate to their needs.

Drinks and snacks in the on-site shop included sugar free and low fat wherever possible. Patients also took part in walking groups, cycling groups, a football league and smoking cessation.

There was an on-site gym that patients could access after 5pm as well as during the day. Among other activities, such as community-based AA meetings, “real work” opportunities, garden activities, a lunch club and on-site patient run café, this reflected the focus on normalising behaviours and life in the wider community.

The education centre offered courses in numeracy and literacy and other courses such as staying safe online. Patients could also access courses specific to their individual interests and needs, for example, vocational courses such as horticulture and catering, or university courses.

There were opportunities for paid “real work”, such as participating in staff recruitment and training, groundwork, painting and decorating and portering. Patients had also facilitated an open day for staff recruitment.

Patients had entered their work for the Koestler Trust awards, including artwork, poetry, music and photography. The Koestler Trust runs an awards programme that encourages participation in the arts and education. Patients had been participating for several years and had regularly been commended or won awards.

Patients had also entered Partnerships in Care’s “greenfingers” gardening competition with the Griffin garden project.

Meeting the needs of all people who use the service

Patients individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, offered choice and ensured continuity of care. Via the patients’ council, which was represented at all levels from ward to governance, patients were involved in the design and delivery of services.

There was a range of information available relating to activities, treatment, safeguarding, patients’ rights and complaints information. Information on mental health problems and medication was available and there were laminated advice sheets on medication on the wards. Smoking cessation information was prominent.

There was information about the independent mental health advocacy service and how to contact the advocate.

Staff had placed clear information on notice boards about activities for the day and there were leaflets about local services and activities.

Information leaflets were available in a range of languages and formats. Interpreters were available and accessed as needed. When they were admitted, patients received information booklets about the ward and service and they were allocated a peer “buddy” to help them settle in and familiarise themselves.

Staff took a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs and promoted equality. This included patients in vulnerable circumstances or those with complex needs. The needs of different patients were



Forensic inpatient/secure wards

taken into account when planning and delivering services. Reasonable adjustments were made and action taken to remove barriers when patients found it hard to use or access services.

On Arkwright ward, we saw that adaptations had been made to accommodate the needs of older patients and ensure an inclusive environment. There were raised flower beds that those less able to bend or with reduced mobility could access and be involved in gardening activities.

There was a private facility for patients to make telephone calls. The door was painted in the style of a red telephone box so that the purpose of the room was clear. Provision on the ward focused on quality of life and a healthy retirement, although patients still had access to the full range of activities. Patients with reduced mobility stated they had no issues with the environment and all areas were fully accessible.

One patient had early onset dementia. A placement at a more specialist service was proving difficult to achieve. In the meantime, staff researched and acquired the skills they needed to develop a one-to-one programme of specialist care to meet the specific needs of this patient.

Staff working on Arkwright ward had undertaken specialist training so that they were able to meet the needs of patients reaching the end of their lives.

Patients told us there was a choice of food, which some described as “very good” and others as “not bad”. Portion control was used to ensure a healthy diet, which the patients saw as positive. Meal choices included options for vegan and halal diets and for patients with allergies or medical conditions such as diabetes. Patients were asked to complete daily food feedback forms. Based on feedback, a “traffic light” system had been introduced to the daily menus so that patients had nutritional information about food choices. The chef met with patients to discuss menus and requirements. There were plans to use tablets for patients to choose their meals each day so that more nutritional information could be made available.

Patients’ cultural and religious needs were met and they had access to spiritual support. There was a multi-faith room on site that contained a variety of materials relevant to various religions and cultures. Local faith representatives visited the wards and could be contacted to ask for a visit. However, one patient was not aware of the multi-faith room.

The provider gave support to patients’ families and carers regarding visit and travel accommodation arrangements so that patients could maintain contact with the people close to them. Skype was also available and staff had invested time in familiarising patients’ family members with Skype.

Listening to and learning from concerns and complaints

We saw that 28 formal complaints had been made in the 12 months ending on 31 August 2015. Of these, eight were upheld, seven were not upheld, one was partially upheld, two were still being looked into and 10 had been withdrawn. None were referred to the parliamentary and health services ombudsman. Each ward kept a log of informal complaints made. Most complaints were about loss or damage to property, access to activities, care and treatment or food. We looked at 10 records and saw that complaints were dealt with promptly.

The patients we spoke with said it was easy to complain or raise a concern and they were treated kindly if they did so. We saw information on the wards about how to complain. There was a complaints officer who spoke with patients and investigated their complaints. Patients were kept updated about their complaints and were given feedback. The ward teams also received feedback and recommendations for improvements following the investigation of a complaint.

Complaints were dealt with openly and transparently. Complaints and concerns were always taken seriously, responded to in a timely way and listened to. All the staff we spoke with were able to explain the complaints procedure. They told us that complaints may be made formally or informally but the complaints process was followed in all instances. Informal complaints were resolved at ward level.

Rigorous and constructive challenge from patients was welcomed and viewed as a way of holding services to account. Staff said complaints emphasised the fact that people see things differently. They viewed complaints as an opportunity to understand the patient perspective better and to improve practice.

There was active review of complaints and concerns and of how they were managed and responded to. All complaints



Forensic inpatient/secure wards

were raised at the daily handover meeting and reviewed at the weekly lead clinicians' meeting and stayed open until they were resolved. Patients were involved in the review via the patients' council.

As a result of complaints and concerns, improvements were made across the services. These were displayed in patient areas on "you said, we did" boards. For example, a "traffic light" system had been introduced to the daily menus so that patients had nutritional information for each option. Pro forma had been introduced to record storage and disposal of patients' belongings more accurately. Patient money sheets had been amended to incorporate printed staff signatures.

Are forensic inpatient/secure wards well-led?

Outstanding



Vision and values

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

The corporate provider had adopted a set of values driven by quality and safety. The vision, values and strategy had been developed through structured planning with regular engagement from internal and external stakeholders, including patients, the people close to them, staff and commissioners. The corporate values were:

- valuing people
- caring safely
- integrity
- working together and
- quality.

There was a proactive approach to seeking out and embedding new and more sustainable models of care. For example, the service had adopted a further set of principles, called the 6Cs, alongside the recovery model. The 6Cs were developed in 2012 by the NHS Commissioning Board against a backdrop of concerns about standards of nursing care in England. They are:

- care
- compassion

- competence
- communication
- courage and
- commitment.

They were being used as a model of care alongside the recovery focused model.

We saw posters of the vision and values displayed and they were integrated into everyday business via team briefs, ward quality matters, quality accounts, "you said, we did", a quarterly carers' newsletter, good news stories, lessons learned and effective handover meetings. One ward manager was a care maker with NHS England. Care makers act as ambassadors for the 6Cs. The patients' council was represented at governance meetings.

Staff understood the vision and direction of the service they worked in at local level and about how their work linked into the vision and values. At each supervision session, managers expected staff to show how they incorporated them into their practice. Our discussions with staff and our observations of care being delivered assured us that the vision and values were embedded in the service and in individual practice. Staff commented that managers were extremely approachable and operate an "open door" policy for staff to raise any issues or concerns. They knew who the senior managers were and throughout our inspection we saw them acknowledging and speaking with each other. The patients we spoke with told us that staff were approachable and caring.

Good governance

Staff told us they had regular contact with the senior management team. They explained the leadership and management structures in their service and they knew who the senior managers were. There was a 'ward to board' model of governance that encouraged and supported staff to be involved in the governance process.

We found all the staff were well managed locally. Managers had the experience, capacity and capability to ensure that the vision and values could be delivered. Staff were clear about their roles and they understood the management structure. They received appropriate training and were appraised and supervised, complaints were investigated, incidents were reported and investigated, changes were made where needed and safeguarding and Mental Health Act (MHA) 1983 procedures were followed.



Forensic inpatient/secure wards

On every ward, staff completed regular audits, monitored via electronic quality dashboards.

Assessments, care plans and risk management plans were audited to ensure they were completed and reviewed regularly. There were also environmental audits that included ligature risk audits, and audits of infection control systems, equipment and medicines. We saw evidence that audit findings were addressed quickly.

Across the teams, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Performance information was used to hold management and staff to account. Staff supervision was carried out at least every month. All staff had a supervision contract that set out both staff and provider expectations of supervision. Staff told us they had been supervised and appraised by their line managers and that they were supported by them as well as by their peers. We looked at records that supported this. The records we reviewed were all up to date.

Staff were responsible for ensuring their training was up to date but their managers also monitored compliance. Staff compliance with mandatory training requirements at 30 September 2015 was 87% across the hospital.. Throughout our inspection we discussed various issues with staff, such as safeguarding, mental capacity and dealing with violence and aggression, and we reviewed care records and supervision notes. We were assured that staff were competent and had the skills necessary for them to carry out their roles.

There was a good governance structure to oversee the operation of the low secure service. There was a handover meeting every morning that all senior managers, ward managers and allied health professionals attended. All the wards held weekly team meetings where service level performance and wider issues were discussed. The ward managers reported to the governance team every week. This included information from patient community meetings and ward team meetings. We found the meetings we attended or saw minutes of to be well structured,

informative and productive, addressing quality issues clearly. Ward managers told us they had sufficient autonomy to carry out their role and they felt supported by the senior managers.

Leadership, morale and staff engagement

Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. They made every effort to deliver and motivated staff to succeed. They actively shaped the culture through effective engagement with staff, patients and their representatives and stakeholders.

Staff told us they felt well supported by their local managers, peers and more senior management. Many commented on the positive relationship they had with their managers. We saw clear examples of strong local leadership from the ward managers, such as implementing initiatives to meet the diverse needs of patients and ensuring the vision and values were embedded into individual practice and service delivery.

The leadership encouraged continuous improvement and there was excellent commitment to quality improvement across all the teams. Staff were motivated to deliver change. Safe innovation was celebrated, for example, after completing leadership training, staff were encouraged to develop a piece of innovative work to implement on their ward. One member of staff had developed a support programme for staff escorting patients on leave.

Staff had opportunities for career progression. Some health care support staff had been supported through training to become registered nurses. Staff support included a childcare scheme and a 24 hour helpline. Less conventional support for staff included relaxation sessions, whereby they could take half an hour out of their shift for a massage, and “working well”. “Working well” involved raffling prizes such as a spa day for staff.

Sickness and absence rates were low at 4%.

Leaders encouraged cooperative, supportive relationships among staff. Staff were proud of the organisation as a place to work and they spoke highly of the culture. They felt respected, valued and supported, and were positive about their jobs. They reported good multidisciplinary team working. Staff were supportive and caring towards each other. We observed all staff interacting as a cohesive team,



Forensic inpatient/secure wards

with a clear understanding of each others roles. They told us they enjoyed their work and were proud of the culture of care. They showed a clear commitment to providing the quality care that patients needed.

Candour, openness, honesty and transparency and challenges to poor practice were encouraged. Managers encouraged staff to be open and honest when things went wrong. The duty of candour was discussed at business meetings so that staff had a good understanding of the duty. Staff we spoke with understood what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Staff understood the whistleblowing process and said they would use it to escalate concerns. They told us they felt able to raise concerns without fear of victimisation, to promote service development and improvement.

Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers. Records we reviewed confirmed this. There were regular staff surveys with action plans for improvements based on the findings. There was a staff consultation meeting every quarter where service developments were discussed.

Staff could nominate colleagues who had impressed them by their practice. Local nominations took place every month. The site winner progressed to be considered for a regional award, then on for a national award. At the time of our inspection, one member of staff had just won the regional award for their work on dementia awareness.

Commitment to quality improvement and innovation

There was a strong commitment to quality improvement and innovation from all staff at all levels.

There were plans for service improvements. A new, interactive system of supported self-management, PathNav, was being piloted that would support patients to plan their care pathway and have increased involvement in their own assessment, goal-setting, treatment and discharge planning. It was anticipated that this would increase levels of engagement with treatment and improve treatment outcomes. A further anticipated benefit was the reduced administrative burden on staff that would free up time to engage more with patients. Staff and patients were being trained in using the new system and there were patient “champions” who promoted it to other patients.

We also saw plans for a new development at Kemple View providing pre-discharge independent living accommodation for 24 patients. The plans had been developed in response to the difficulty in finding suitable placements for some patients and work was due to commence in March 2016.






In April 2015, the low secure service had been reviewed by the Royal College of Psychiatrists as part of the quality network for forensic services and fully met 95% of low secure standards, compared with a national benchmark of 81%. The report outlined key achievements including the recovery focus ethos, effective discharge planning and the wide range of “real work” opportunities both within the service and in the community.

The service had links with the University of Nottingham to develop patient involvement in the knowledge and understanding framework for personality disorder.

Kemple View had received an award for good practice for patient involvement in the annual “design in mental health” awards.

Long stay/rehabilitation mental health wards for working age adults

Outstanding 

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good 

Safe and Clean Environment

Both rehabilitation wards had generous space for communal and individual activities, including rehabilitation kitchens, quiet areas for patients and visiting areas for relatives, friends and carers.

All patient areas were light and spacious with comfortable furniture. The living areas looked homely and both wards had large fish tanks. Patients had access to the lounge and dining areas throughout the day and were able to make their own drinks and snacks whenever they wanted.

The ward atmosphere was calm and positive. Both wards had access to outdoor areas that were spacious and well maintained and accessible to patients.

All patients had their own individual bedrooms with an ensuite toilet and sink. The bedrooms were spacious and had a lockable cupboard for personal items. There were additional showers and bathrooms. There were nurse alarms for patients who may need urgent assistance.

All areas were clean and in good repair. Records indicated that staff monitored hygiene and tidiness daily. Staff followed infection control practices and had access to protective personal equipment such as gloves and aprons.

Both clinic areas were in good order, and resuscitation equipment was available and accessible. We saw records detailing regular checks of all equipment and emergency

medication. These checks were in date. Fridge temperatures were checked daily and the records were all up-to-date. Staff carried out weekly audits of medication. We checked the ward “grab bags” and emergency first aid bags. The contents were all present and in-date.

There was a GP suite on the hospital site that had a fully equipped examination area. Patients who needed to be examined either went to the GP suite or were visited on the ward by the practice nurses.

There were blind spots and ligature points identified in environmental risk assessments. A ligature point is anything that could be used by a patient to harm themselves.

The provider had assessed the risks and taken action to reduce them through staff awareness, using mirrors, observation, care planning including clinical risk assessment and individual levels of observation, and good relational security. The risks were reviewed every month. Staff understood the risk to patients’ safety presented by the layout of the wards and each patient had received an individual risk assessment.

Doors to the wards were locked and staff, patients and visitors entered and left the wards via an airlock. All staff were familiar with the safe management of keys and were aware of the appropriate policies and procedures in respect of security. New staff completed a security induction before they were given keys and all staff underwent annual security training. Staff had personal alarms to call for assistance, which were linked to other wards in the hospital. There was a clear assistance protocol to respond to incidents on the wards.

Long stay/rehabilitation mental health wards for working age adults

Outstanding



The rehabilitation wards did not have seclusion rooms. Patients who needed to be cared for in seclusion were taken to one of two rooms on the low secure wards.

Each ward had a designated security nurse on each shift who was responsible for access, security and safety. All staff were able to tell us what needed to be checked to maintain the physical security and safety of their ward.

All the staff we spoke with understood the significance of building trust, setting and maintaining boundaries and understanding the patient group dynamic. They understood how to keep patients safe from avoidable harm and provide high quality care.

The wards had a designated health and safety representative, supported by a qualified full-time staff member responsible for all health and safety issues.

Safe staffing

Each ward had the following full time equivalent staff in post:

Hawthorn

- 1 ward manager
- 2 charge nurses
- 6 staff nurses
- 16.3 health care support workers

Oakwood

- 1 ward manager
- 2 charge nurses
- 7 staff nurses
- 17.9 health care support workers

The provider assessed staffing need using a safe staffing tool developed in line with Compassion in Practice (NHS commissioning board 2012). The base staffing calculation involved consideration of the number of patients, the level of care they required and the resources needed to provide that care. Managers responded quickly and adequately to staff shortages. Staffing levels and the skill mix within the teams meant the staff on duty were able to meet patients' needs and deliver safe care and treatment. All staff told us there were sufficient numbers of staff to deliver the care and support that patients needed. The wards had a two-shift system with two qualified nurses and four healthcare assistants during the day, and one qualified

nurse and three healthcare assistants during the night. Handovers occurred at the change of every shift and ensured staff understood issues relating to patient safety and risks.

The wards had enough staff on duty to meet the needs of the patients and there were no vacancies at the time of the inspection. Staff turnover for the hospital was 19.4% and the sickness rate was 4%. The wards used a bank of known staff to fill vacant shifts and staff rotated in the hospital to cover unexpected shortages. This ensured staffing consistency across both wards. In the three months before our inspection at Hawthorn ward, 141 out of 145 shifts were covered by bank staff for reasons of sickness and absence, with 66 out of 79 at Oakwood ward.

Staff told us that any shortfall could be covered by other suitably trained staff from within the hospital if necessary. Managers planned and arranged cover for leave and vacancies. Staff and patients informed us that it was rare that activities and leave were cancelled due to staffing shortages.

There was sufficient medical cover during the day and night. Ward rounds for each consultant took place every week and five patients were seen each week, so every patient was seen monthly. However, this was adjusted when patients were unwell and they were seen more often.

A doctor could attend in an emergency and was available on call out of hours. Consultants provided on call support for one week out of four. Medical staff were required to be able to attend within one hour of being contacted.

Managers monitored compliance with mandatory training via an electronic system that alerted managers when refresher training was due. As of the 31 August 2015, the mandatory training levels for the hospital were:

- basic life support 72%
- breakaway training 93%
- conflict resolution 91%
- equality, diversity and human rights 61%
- fire safety 96%
- food hygiene 66%
- health and safety 95%
- Infection control 98%
- information governance 88%
- mental health act 80%
- moving and handling 93%
- managing violence and aggression 88%

Long stay/rehabilitation mental health wards for working age adults

Outstanding



- safeguarding adults level 1 83%
- security 75%.

Staff induction included training on relational security.

Online training had recently been introduced via a system called iLearn. Staff could access the system whether they were on- or off-site and they received protected time to complete mandatory training. They could monitor their own training and ensure they kept up to date. The system flagged up expiry dates for mandatory training. There were options for learning; staff could book onto classroom sessions or complete interactive e-learning courses followed by an e-assessment to ensure their competence. There was also a five stage audit that randomly checked staffs' knowledge of various topics, for example, safeguarding.

On the day we inspected we saw electronic dashboards that showed mandatory training levels had increased to 100% for both rehabilitation wards.

Assessing and managing risk to patients and staff

We looked at the risk assessments for 11 patients. All the records were complete and up to date.

The multidisciplinary team completed a pre-admission assessment. On admission, a 72-hour care plan was written for all patients and adjusted during the first three months.

Staff responded appropriately to changes in risks to patients. During the first three months of admission, they assessed and monitored risks to patients using recognised tools such as the historical clinical risk management (HCR-20) and the short-term assessment of risk and treatability (START).

The HCR-20 tool assesses the patient's risk of violence in the present and future.

The START tool measures the patient's own perception of their strengths and vulnerabilities. The assessment was carried out between each patient and clinical team twice a year. The scores measured the patient's progress. Patients' own perception of their strengths and vulnerabilities, which rises as they gain insight into their mental health, is expected to increase as their treatment progresses.

Staff assessed, monitored and managed risk to patients on a day-to-day basis. Risk assessments were person-centred, proportionate and reviewed regularly. Patients were

involved in managing risks. Staff recognised and responded appropriately to changes to risks in patients. These included signs of deteriorating health, medical emergencies or behaviour that challenged.

The practice nurses carried out physical health assessments on admission. The practice nurses carried out therapeutic drug monitoring for patients prescribed medicines such as clozapine, to ensure their physical wellbeing. They also ensured patients had full written information before commencing the medication.

There was a service level agreement with a local GP surgery to provide a weekly clinic for patients.

Staff received training in de-escalation and management of violence and aggression techniques. Staff were trained in "reinforce appropriate, implode disruptive" (RAID) techniques that used positive behaviour reinforcement to deal with potentially violent situations. RAID involved all staff including housekeepers and other ancillary staff. Staff and patients told us they believed this approach was having a positive effect on reducing incidents of violence and aggression. In the last 12 months there had only been two serious incidents recorded that involved violence. RAID training is accredited by the association for psychological therapies. Staff used a traffic light system as part of the RAID approach to prioritise those patients who required enhanced support.

In the six months up to 30 September 2015, there had been 13 incidents of restraint for six different patients, three of which had started in the prone position (face down). Staff turned patients into a face up position as soon as possible to ensure the safety of the patient. None of the physical restraints had resulted in the use of rapid tranquilisation.

During the same time period, there had been 8 incidences of seclusion, all from Hawthorn ward. Staff completed seclusion records in accordance with the Mental Health Act 1983 (MHA) code of practice. Staff assessed patients in seclusion routinely. They reviewed whether the patient needed to remain in seclusion in line with the hospital policy and the code of practice. The records we saw set out the need to continue seclusion and documented the patient's response to staff trying to engage with them. The use of seclusion was also reviewed at the daily morning handover meeting.

We found an embedded culture of positive risk taking and least restrictive practice. There was a "least restrictive

Long stay/rehabilitation mental health wards for working age adults

Outstanding



practice” champion on each ward who was responsible for offering advice and support to other staff and disseminating information. Many patients had ground or community leave and were utilising this during our visit. Patients had access to their rooms at all times except between 9.00am and 11.00am when the rooms were being cleaned. Patients had access to a range of “real work” opportunities, both on-site and in the community.

It was recognised that some restrictive practices were necessary for environmental security and patient safety purposes. For example, patients kept their own cigarettes but staff held their lighters or matches.

However, some practices were disproportionately restrictive. For example, the wards had fenced courtyards but patients’ access to these areas was limited to access supervised by staff. The doors were locked and patients had to ask to access these areas. The reason for this was not clear as the gardens were secure within the wards. Patients could ask for additional access to the garden areas and this was then subject to individual risk assessment by the MDT. Following risk assessment, some patients had un-escorted access to this outside space and were provided with an electronic key fob to gain access.

Patients had access to personal mobile phones in line with local policies and procedures. The MDT risk assessed each patient who wanted access to a mobile phone. Care plans included details of the level of access and risk. Patients were required to hand their personal mobile phones to staff at 10.00pm each day although they could request unrestricted access to their mobile phones. The MDT risk assessed each request individually, taking account of the patient’s mental state and any history of nuisance calls.

Care plans included allowing staff to monitor usage of the phones when patients handed them in. All mobile phones were subject to random checks and compliance with the individual patient’s mobile phone contract.

We found good examples of positive risk taking. Instead of searching all patients every time they returned from leave, staff were using technology so that patients to be searched were selected at random.

The service only admitted patients detained under the Mental Health Act 1983; however, on occasion patients already in hospital were discharged from detention under the Act. Any decision that an informal patient would remain at the hospital was made in conjunction with the referring

team and reflected a plan for the patient’s future. There was a policy to guide staff in managing these patients, and an information leaflet for patients. We saw a care plan that had been agreed with an informal patient that protected them and contained, for example, agreement to inform staff when they were leaving the ward, not to bring contraband items onto the ward and not to return to the ward intoxicated. The patient had a copy of the plan.

There were clearly defined systems and standard operating procedures to keep patients safeguarded from abuse. These were embedded in practice across the wards. Safeguarding arrangements took account of both adult and child safeguarding. All staff had received mandatory training in safeguarding at level one. Safeguarding information was displayed in the wards. There was a safeguarding policy and procedures for staff guidance. Social workers also provided guidance. There were good links with the local safeguarding authority. We discussed safeguarding with staff. We were assured that they had a good understanding of safeguarding issues and how to make a safeguarding alert. Staff recorded and reported safeguarding incidents appropriately.

There were policies and procedures covering all aspects of medicines management. Staff received training in medicines management and had a good understanding of safe medicines management.

Qualified staff carried out a medicines audit every weekend. The audit included checking that appropriate authority to treat had been obtained, ensuring medicine stocks were accurate and in date, and checks of the clinic room and equipment including emergency equipment.

There was a policy that set out arrangements for child visitors. There was a designated room away from the ward areas for visits.

The provider assessed, planned for and managed risks to safety from service developments and anticipated changes in demand. There were plans for responding to emergencies and major situations. There was a contingency plan covering serious incidents, such as loss of control, serious operational failures, escapes and hostage taking.

Track record on safety

From October 2014 to 30 September 2015, there had been four recorded serious incidents on Hawthorn ward. These

Long stay/rehabilitation mental health wards for working age adults

Outstanding



comprised a medication error, an incident of self-harm and two assaults. None had occurred in the last six months. The provider had investigated all the incidents. We saw instances of learning following investigation of these incidents, for example, a detailed protocol setting out the management of self-harming behaviour, including prevention and treatment.

Reporting incidents and learning when things go wrong

Staff understood their responsibilities to raise concerns and report incidents and near misses, and managers supported them to do so. There was an electronic incident reporting system. This enabled ward managers and senior managers to review and grade the severity of incidents.

We spoke with staff and reviewed staff communications and meeting notes. We were assured that the provider adhered to principles of openness and transparency about safety. When something went wrong, patients received a sincere and timely apology and information about any actions taken to prevent re-occurrence.

Learning points were communicated widely in the hospital and throughout the provider's other locations. Senior managers and all ward managers attended a daily morning meeting where they discussed all reported incidents and the action to take. Ward managers fed back to their teams. This meant staff understood risks and gave a clear, accurate and current picture of safety. Staff had a team briefing system and opportunities to discuss learning from incidents and complaints through team meetings and supervision. We saw examples of improvements to safety and changes made to practice, which were action planned and monitored for effectiveness.

Staff and patients received de-briefing following serious incidents. De-briefing incorporated support and reflective discussion and input from a psychologist. The staff we met with described an embedded open and supportive culture. They said they felt well supported by managers and their colleagues. Patients also told us they felt well supported.

Duty of Candour

Staff understood their responsibilities relating to the duty of candour. We were assured from our discussions with

staff that they understood what a notifiable safety incident was and what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good



Assessment of needs and planning of care

Staff took a holistic approach to planning care, focusing on recovery in terms of relapse prevention, early warning signs, support networks and self-harm reduction. The hospital had a recovery lead and a recovery champion on each ward. They were responsible for offering advice and support to other staff and disseminating information.

We looked at 11 care records and found they contained referrals, comprehensive assessments, and care plans. Staff carried out holistic assessments of patients' needs that covered clinical needs, mental health, physical health and wellbeing, and nutritional and hydration needs. The assessments focused on patients' strengths, self-awareness and support systems, in line with recovery approaches.

Care records showed that the multidisciplinary team (MDT) and patients worked together to regularly review and update assessments and care plans. Staff routinely recorded and monitored information about care, treatment and outcomes. All the records we reviewed showed a clear care pathway. They were recovery focused and showed knowledge of current, evidence-based practice.

Patients confirmed that they had regular sessions with their primary nurse to discuss and review their care plans, and that they attended review meetings with the MDT. Changes in care and treatment were agreed with the patient and entered on the electronic care notes system. The records were projected onto a screen so that the changes were visible as they were made. Families and carers were encouraged to be involved in the care planning process.

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All care records were stored electronically. Paper records, such as MHA documentation, were stored securely. They were also scanned onto the electronic system so that they were available to all staff when needed. Access was protected to ensure the records remained secure.

Best practice in treatment and care

Staff planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Staff implemented evidence-based guidance within their clinical practice, for example, in line with the National Institute for Health and Care Excellence (NICE) and Department of Health guidelines relating to risk management, aggression and violence and schizophrenia. Care plans also referenced national guidance. We reviewed supervision records and they confirmed staff were using NICE guidelines, for example, in relation to risk management.

A team of psychologists delivered a comprehensive programme of therapeutic support. Some work took place in groups but most was undertaken in 1:1 personalised programmes. Patients could refer themselves or the multidisciplinary team (MDT) could make a referral. Interventions included motivational cognitive behaviour therapy techniques, emotional regulation, mindfulness, responsible living, substance misuse awareness, dialectic behaviour therapy, a sexual behaviour management programme and “reinforce appropriate, implode disruptive” (RAID) techniques.

RAID uses positive behaviour reinforcement to deal with potentially violent situations. It is a recognised industry standard method of working with patients to help them manage their own behaviour, accredited by the association for psychological therapies. Kemple View was a RAID centre of excellence. Being recognised as a RAID Centre of Excellence means that that the organisation is implementing RAID principles outstandingly well, using a positive approach to interventions. The centre of excellence status is re-appraised at least every two years to ensure its current validity.

Staff measured and monitored patient health scores with the use of electronic dashboards, in line with the hospital’s physical health strategy. The care records we reviewed included full physical healthcare checks, including a routine electrocardiogram within 24 hours of admission and every year afterwards.

There was a service level agreement with a local GP surgery to provide a weekly clinic that included monitoring of chronic illness.

Staff audited the effectiveness of interventions using nationally recognised assessment tools, such as the historical clinical risk management-20, the short-term assessment of risk and treatability and the health of the nation outcome scales. They used the Liverpool University neuroleptic side effect rating scale to monitor the side effects of medication. Some patients were using the “recovery star” and “my shared pathway” to measure their progress. Information about effectiveness was shared, for example, via MDT and governance meetings and reports published internally and externally, and used to improve care and treatment and patients’ outcomes.

The service took part in national audits such as the national audit of schizophrenia and the NHS benchmarking audit of restraint.

There were effective policies for the management of medicines and the hospital took part in the prescribing observatory for mental health (POMH-UK) audits, such as prescribing for personality disorder.

The service used the commissioning for quality and innovation framework as quality indicators. Currently these included involving patients in formulating and updating risk assessments and implementing quality dashboards. There were clear timescales and action plans that staff regularly reviewed.

Skilled staff to deliver care

Patients had access to a range of mental health disciplines to aid their recovery. A number of different professionals made up the multidisciplinary team including a responsible clinician, psychologists, the nursing team, a social worker, and an occupational therapist.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Their learning needs were identified as part of the supervision and appraisal process. Staff were supported to maintain and further develop their professional skills and experience.

There was a strong focus on improvement and many opportunities for learning and sharing across the service. We found examples of good or excellent practice across the wards. Safe innovation was supported. Staff were

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Outstanding



encouraged to take time out to reflect on their practice and make improvements, for example, case formulation and reflective practice groups were available for all staff at each ward. The staff we spoke with said they found discussion of challenging clinical issues invaluable in exploring ways to improve the service they provided.

Staff skills and continuing development was acknowledged as central to good care. Managers proactively supported to staff acquire new skills and share best practice. We reviewed the records of 12 staff working in the service. Their training records showed that they had accessed a range of training. Supervision records contained notes about training needs and training undertaken. Managers encouraged staff to develop skills in specialist areas. For example, staff had undertaken leadership training and were encouraged to develop a piece of innovative work to implement on their ward. One member of staff had produced a protocol to support patients to develop self-catering skills, including meal planning, budgeting and shopping, staged so that patients could advance from cooking three meals per week to two per day. Other staff had done work on implementing preferred priorities of care, making meaningful differences, an electronic ward diary and raising awareness and developing least restrictive practice.

Some nurses had previously been health care support workers and the provider had supported them through university in order to become registered nurses. Other disciplines also said that the provider had paid for and supported them to gain further qualifications in order to improve patient care. There were also reciprocal arrangements with local organisations for specialist training, for example, around substance misuse.

New staff underwent a comprehensive induction that incorporated the care certificate for non-registered clinical staff. The care certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It sets out national standards that underpin the skills, knowledge and behaviours to ensure staff provide compassionate and high quality care and support.

All nursing staff had had an appraisal in the 12 months prior to this inspection. Appraisal included setting objectives for personal development. Out of three medical staff, two had been revalidated in the 12 months prior to this inspection.

Staff received clinical and managerial supervision every month. The provider's values were linked to supervision and appraisal. Supervision was embedded in the nursing culture of the wards. Every member of staff had a supervision "passport" in which they recorded all types of supervision. This included group supervision, reflective learning and informal discussions as well as formal sessions with their supervisor. Formal supervision records included discussion of appraisal objectives, NICE guidelines, training needs and patient engagement.

There was a clear and appropriate approach to supporting and managing staff when their performance was poor. Staff and managers discussed performance in one-to-one supervision sessions. We saw evidence of this in the records we looked at. Managers explained the process they followed and told us they felt well supported in dealing with poor performance.

Multidisciplinary and inter agency team work

Staff worked collaboratively to understand and meet the range and complexity of patient's needs. The multidisciplinary team (MDT) worked effectively to coordinate person-centred patient care and support patients' recovery in line with best practice guidance. The MDT held weekly meetings, with the patient's involvement. Open invitations were offered to care coordinators and carers and there were good relationships with community teams.

We observed one of these meetings. We found clear commitment to joint working so that the patient received the best possible care. The MDT planned care and treatment in a holistic, patient focused way. They took great care in seeking the patients' views and opinions to ensure they were involved in developing the plan.

Handovers occurred at the change of every shift. They were chaired by a senior member of ward staff. Staff discussed issues relating to patient safety, risks and observation levels. Additionally, every morning, senior managers and all ward managers met to review issues such as referrals, admissions, discharges and transfers, incidents reported, observation levels, risks, safeguarding and complaints. We attended one of these meetings and found it to be well structured, informative and productive.

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We reviewed minutes of monthly ward business meetings. Discussions included team performance, training, safeguarding, safety alerts and communications, outcomes measurement and the duty of candour.

There were established positive working relationships with other service providers such as GPs chiropody, opticians, podiatry and physiotherapy and with a range of community services and groups where patients could undertake voluntary and vocational work placements. Some patients were involved in charity work such as Macmillan, and the annual “stoptober” stop smoking campaign.

Adherence to the Mental Health Act and MHA code of practice

Where people were subject to the Mental Health Act 1983 (MHA), their rights were

protected and staff complied with the MHA code of practice. Adherence to the MHA and associated code of practice was good.

Mental Health Act (MHA) training was part of the mandatory training calendar and 98% of staff were up-to-date. Staff had a good understanding of the MHA and the associated code of practice. Patients had regular discussions with staff who provided them with information about their rights under the MHA. For example, patients understood their right to appeal to the mental health review tribunal (MHRT) and/or the hospital managers and we saw evidence in patient files that some had exercised this right.

We also saw that when necessary, referrals had been made by the hospital to the MHRT. Hospital manager’s decisions were clearly and appropriately recorded and the patients were informed of the decisions in line with the MHA Code of Practice.

The provider had introduced new policies to guide staff in implementing the changes to the code of practice in 2015. In addition, there was a “least restrictive practice” champion on each ward who was responsible for offering advice and support to other staff and disseminating information.

In the patient files we looked at, all the statutory detention documentation was in order. The procedures for renewal of detention had been followed and there was evidence that the criteria for renewal had been met.

All treatment was given under an appropriate legal authority and T2 and T3 certificates were in place. Section 61 documentation was also evident for those on T3s when required. The responsible clinician had made a note of patients’ capacity to consent to treatment at the most recent authorisation. Requests for second opinion appointed doctors had been made where appropriate.

There was an independent mental health advocate (IMHA) who provided support to patients on request. The IMHA visited the wards each week to ensure patients were aware of the support that the IMHA could provide.

Good practice in applying the Mental Capacity Act

Ninety eight per cent of staff had undertaken Mental Capacity Act (MCA) 2005 training at the time of the inspection. Staff understood and complied with the requirements of the MCA. Staff understood that capacity fluctuated and that patients may have capacity to consent to some things but not others. There was a policy that staff could refer to and the social work team provided guidance.

Staff supported patients to make their own decisions about their care and treatment wherever possible. They obtained consent to care and treatment in line with the MCA. All patients had a preferred priority care plan that contained advance decisions, for example around end of life care should it become necessary.

Staff assumed that patients had capacity and dealt with capacity issues on a decision-specific basis. They supported patients to make decisions and, where appropriate, they assessed and recorded patients’ mental capacity. The process for seeking consent was monitored.

Staff supported patients to make decisions and, where appropriate, assessed and recorded their mental capacity. Staff carried out mental capacity assessments only when there were doubts about the patient’s mental capacity. This meant that patients received appropriate support to help them make specific decisions.

There were no patients subject to the deprivation of liberty safeguards (DoLS) and there were no pending DoLS applications.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Long stay/rehabilitation mental health wards for working age adults

Outstanding



Outstanding



Kindness, dignity, respect and support

We observed staff interactions with patients that were respectful, warm and good humoured. All staff we spoke with were responsive, caring and enthusiastic about patient care and progress.

There was a strong, visible person-centred culture. Staff were highly motivated to offer care that was kind and promoted patient's dignity. Relationships between patients, their relatives and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by managers.

Feedback from patients was overwhelmingly positive about the way staff treated them. One relative described how they thought that staff went the extra mile and the care their relative received exceeded expectations.

All patients were allocated a nurse to orient them to the ward on admission and provide information about their rights under the Mental Health Act, choice of treatments available to them, access to advocacy and discharge planning. Information packs were also available to all to support this.

There was good evidence in patients' care plans of their involvement in care planning. The plans were holistic, personalised and recovery-oriented. Staff always empowered patients who used the service to have a voice and to realise their potential. Patients' individual preferences and needs were always reflected in how care was delivered taking into account their emotional and social needs.

The involvement of people in the care they receive

We found excellent commitment to genuine patient involvement. At the beginning of the inspection, patients, staff and the hospital director presented an overview of the service with their achievements and plans for the future. A representative of the patients' council took a lead role in this. Putting patients at the centre of the service, involving and empowering them was clearly embedded in the hospital culture.

Each new patient was allocated a patient 'buddy' to welcome them to the ward and help them settle in. There was a welcome booklet designed by the patients, with information about the ward and service.

Staff empowered patients as partners in their care. Their individual preferences and needs were reflected in how their care was delivered. Patients and staff worked together to plan care. We saw staff spending time talking with patients. Patients told us they understood their care, treatment and condition. They were involved in influencing their care and treatment, including planning for their discharge.

For example, patients contributed to their own care records. We saw examples of care plans that clearly set out patients' views and their involvement in developing them. If the patient wished, their family, friends and advocates were involved in their care. Patients all had a copy of their own care plan.

Every day, patients reflected on the day and completed a diary, either by themselves or with staff. They used the diaries to add their own notes to their care records.

We observed one multidisciplinary meeting. The patient was involved and consulted about every aspect of their care.

Patients also had the opportunity to chair their own care programme approach meetings and choose who should be invited, including their family members if they wished. Staff and patients discussed progress, risk management and care planning together. They reviewed care plans and risk assessments during the meeting. This meant there was plenty of opportunity for discussion and agreement with patients and staff. Changes were entered directly into the electronic notes and a projector was used so that everyone in the meeting could see the record. This ensured patients had the opportunity to comment on the report as it was written.

Community meetings were held every week where patients had an opportunity to discuss wider hospital issues and have a say in the day-to-day matters of the ward. Patients were actively encouraged to be part of community meetings. We saw minutes of some of these meetings that documented discussion about issues patients raised. Action plans were in place to address these and patients felt listened to and were confident that staff acted in their best interests.

Long stay/rehabilitation mental health wards for working age adults

Outstanding



Patients were also involved in hospital governance via the patients' council. This was an integral part of systems to ensure the voice of the patients was prominent within the organisation. Both wards had patient representatives who sat on the patients' council to ensure that patients' voices were heard.

The patients' council meetings were chaired by patients, with support from the hospital director, and attended by all heads of departments. Part of the patient representative role was to take information from matters discussed at the council back to their peers on the wards. They would also take matters to the council that were raised by fellow patients for discussion and consideration if those matters could not be resolved at ward level through the community meeting. The patients' council had a strong voice and was represented at governance meetings, where they were involved in discussion and decisions about matters such as funding, service issues and developments. We saw meeting minutes that clearly confirmed the respect given to patients' views and opinions.

Patients were supported to maintain their relationships with the people close to them, their social networks and community. Staff helped them to manage their own health and care whenever possible, and to maintain their independence. Some patients had the opportunity to self-cater and many had access to an extensive range of paid "real work" opportunities, both on-site and in the community. Patients attended interviews for these posts and were paid for the work they carried out. On-site, opportunities included sitting on interview panels for staff recruitment and being involved in staff induction and training. Patients received training to support them to do this effectively. Other opportunities included working in the on-site café, which involved ordering supplies, choosing healthy options, preparing food and sales. Patients also ran a lunch club every week. Off-site opportunities included gardening, involvement with charities and work in local businesses. Both patients and staff were positive about the programme, which they viewed as a real experience of work that was recovery focused.

Staff offered support to patients' families and friends that meant patients were able to maintain their relationships with the people close to them. There was a quarterly carers' meeting and visitors were offered assistance with transport where they needed it in order to be able to visit their relatives.

There was excellent support for patients and their families in the use of technology. Skype facilities were available so that patients could more easily maintain their relationships with the people close to them, particularly where there was significant distance. As well as assisting patients, the service had invested time in familiarising patients' friends and families with the use of Skype.

There were regular patient surveys. Action plans for improvements were developed from the findings. We saw that a patient led review of the "real work opportunities" programme was scheduled to take place in early 2016.

An independent mental health advocate (IMHA) visited the wards each week to ensure that patients were aware of the support that the IMHA could provide. Patients had direct access to advocacy services and there was information displayed across all the wards.

All patients had preferred priority care plans that contained advance decisions, for example, around end of life care, should it become necessary.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Outstanding



Access and discharge

We found evidence of comprehensive admission procedures. The care programme approach (CPA) was used as a framework and timeline for planning and coordinating support and treatment.

Patients were admitted from a range of different settings including secure units, prisons and other inpatient units. All admissions were planned.

Pathways to rehabilitation were clear and patients were assessed prior to admission to ensure they would be receiving the most appropriate care and treatment.

Patients were admitted from various parts of the UK due to placements that would meet their needs not always being available in their home area.

Long stay/rehabilitation mental health wards for working age adults

Outstanding



Bed occupancy had been consistent and the average length of stay was 12 months to two years. In the six months prior to this inspection, average bed occupancy for Hawthorn ward was 94% and Oakwood ward was 96%.

The service worked within the principles of the recovery model. This meant they focused on helping patients to be in control of their lives and building their resilience so that they could regain a meaningful life. This helped to reduce the risk of patients relapsing during their recovery. This meant that staff ensured patients did not stay in hospital longer than necessary and promoted early discharge.

Discharge planning was collaborative and took into account individual needs, circumstances and ongoing care arrangements. Staff liaised with the patient's care coordinator. Patients were discharged at an appropriate time and when all necessary care arrangements were in place.

We saw evidence of planning for discharge, transfer or transition to other services, including potential future placements. Discharge plans were developed in care planning. All the patients and carers we spoke with were aware of plans for discharge. Staff considered discharge arrangements from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. This included providing support to patients during periods of leave.

There had been one delayed discharge in the six months before this inspection. This was due to difficulties with the availability of the identified placement.

Care and treatment was coordinated with other services and other providers. Staff worked closely with care coordinators to ensure that patients were helped through their discharge. Staff told us that external care coordinators sometimes found it difficult to attend care programme approach (CPA) meetings; however, this was beyond the control of the service. Tele- and video-conferencing was used to facilitate their input. Discharges or transfers were discussed in the multidisciplinary team (MDT) meeting and were managed in a planned and coordinated way. There was a care pathway from the low secure wards into the locked rehabilitation wards depending on individual needs. Staff worked closely with commissioners to facilitate transfers and discharges.

The facilities promote recovery, comfort, dignity and confidentiality

The ward facilities and premises were suitable to promote recovery and support care and treatment. Clinic rooms were clean and well equipped. There were rooms where patients could relax and watch TV or engage in therapeutic activities. These included quiet areas, activity and meeting rooms and sports areas. Each ward had a room where patients could meet visitors. These were away from the main ward area and afforded privacy for patients and their visitors. There was a separate room away from the wards for visits with children. All patients had access to a telephone, which was in a private booth. The independent mental health advocate could be contacted by pressing one button on the phone. Patients had supervised access to the internet via a computer on the ward. There were initiatives to enable patients to keep in touch with relatives who had difficulty visiting, such as the use of Skype, which is software that enables patients to make video and audio calls. Patients we spoke with felt the quality of food was good. Staff sought regular assessment and feedback on the quality of food. Some patients had the opportunity to self-cater.

Patients were actively involved in decisions on the décor and the amenities available to them within the hospital setting via community meeting discussions.

Patients had access to a range of "real work" opportunities, both on-site and in the community. The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patients' needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers. Patients were supported to attend community groups and activities; for example, neighbourhood groups, learning, vocational or volunteer opportunities. This helped patients to take part in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to. Social inclusion is closely linked with recovery. Services have a key role in supporting patients to take part in mainstream activities.

Secure garden areas within the wards provided access to outside space, although this was subject to restrictions, and included a smoking area. The hospital grounds were spacious with gardens, a woodland walk and seating areas.

Long stay/rehabilitation mental health wards for working age adults

Outstanding



On the wards, there were rehabilitation kitchens that were open all day and closed at 12pm although there were areas where patients could make drinks after this time. Staff supported patients to shop for and cook their own food and budgets were available for this.

Staff encouraged patients to personalise their bedrooms. Some patients showed us their bedrooms, which contained personal items such as photographs, pictures, books and CDs. Each room had a locker where patients could store personal property securely.

There was a full range of facilities available to patients seven days a week. Patients had access to a large horticultural area with some animals, training suite and sports hall, IT suite, education room, art and music rooms, woodwork workshop and therapy rooms located across the site. The sports hall was also used for social events such as cinema nights.

There was a wide variety of activities available. These included woodwork, gardening, arts and crafts, music and therapeutic groups, swimming, cycling, boxercise, a gym, smoking cessation and mindfulness groups. Activity focused on promoting recovery and developing skills to maintain independence.

There were opportunities to be involved in activities in the surrounding local communities. Patients were encouraged to use community facilities wherever possible, reflecting the focus on normalising behaviours and life in the wider community. Leave authorised under section 17 Mental Health Act 1983 was well structured, which meant that patients could access a range of activities.

There were several initiatives to improve physical health and encourage healthy lifestyles.

A series of 12-week programmes called “mission fit” were under way during our inspection. The programme incorporated education about healthy living as well as taking part in exercise sessions. It was run by a qualified fitness instructor, using visual aids and actual examples to ensure learning for patients was appropriate to their needs.

Drinks and snacks in the café and shop on-site were sugar free and low fat wherever possible. Patients also took part in walking groups, cycling groups, a football league and smoking cessation.

There was an on-site gym that patients could access after 5pm as well as during the day. Among other activities, such

as community-based AA meetings, “real work” opportunities, garden activities, a lunch club and on-site patient run café, this reflected the focus on normalising behaviours and life in the wider community.

The education centre offered courses in numeracy and literacy and other courses such as staying safe online. Patients could also access courses specific to their individual interests and needs, for example, vocational courses such as horticulture and catering, or university courses.

There were opportunities for paid “real work”, such as participating in staff recruitment and training, groundwork, painting and decorating and portering. Patients had also facilitated an open day for staff recruitment.

Meeting the needs of all people who use the service

Patients’ individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, offered choice and ensured continuity of care. Patients were involved in the design and delivery of services via the patients’ council, which was represented at all levels from ward to governance.

Staff took a proactive approach to understanding the needs of different groups of patients and to delivering care in a way that met their needs and promoted equality. This included patients in vulnerable circumstances or those with complex needs. The needs of different patients were taken into account when planning and delivering services. Reasonable adjustments were made and action taken to remove barriers when patients found it hard to use or access services.

Facilities and accommodation were available for patients requiring disabled access. There were bedrooms on the ground floor to accommodate patients with mobility issues, and accessible bathroom access for those who needed it. Staff made every effort to ensure that services, buildings and facilities were accessible to all whatever their disability.

There was a range of information available relating to activities, treatment, safeguarding, patients’ rights and complaints information. Information on mental health problems and medication was available and there were laminated advice sheets on medication on the wards.

There was information about the independent mental health advocacy service and how to contact the advocate.

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Outstanding



A welcome pack was available to all new admissions to help orientate them to the environment, and they were allocated a peer “buddy” to help them settle in and familiarise themselves.

Staff had placed clear information on notice boards about activities for the day and there were leaflets about local services and activities.

Staff could obtain information in different formats (such as braille) or in different languages, if required. Interpreters were available and accessed as needed.

The provider employed a full-time education facilitator who offered a range of educational opportunities for patients.

Staff offered health promotion activities to patients, such as walking groups, healthy eating, access to the gym and men’s health initiatives. Smoking cessation information was prominent on the wards. There was also a new initiative called ‘mission fit’, facilitated by a fitness instructor who conducted an educational programme about healthy living and encouraged participation in exercise sessions.

Patients told us there was a choice of food, which some described as “very good” and others as “not bad”. Portion control was used to ensure a healthy diet, which the patients saw as positive. Meal choices included options for vegan and halal diets and for patients with allergies or medical conditions such as diabetes. Patients were asked to complete daily food feedback forms. Based on feedback, a “traffic light” system had been introduced to the daily menus so that patients had nutritional information about food choices. The chef met with patients to discuss menus and requirements. There were plans to use tablets for patients to choose their meals each day so that more nutritional information could be made available.

The hospital supported patients’ spiritual and religious needs with a dedicated room for prayer. Equipment related to different religions was available for use in this area. Staff told us that they would facilitate all patients’ religious and spiritual needs, preferably within the local community.

There were excellent opportunities for patients to have real work experiences, both on-site and in the local community.

The provider had made good links with external organisations and some patients were experiencing real work opportunities in order to support and aid their rehabilitation.

Patients were supported to attend community groups and activities; for example, neighbourhood groups, learning, vocational or volunteer opportunities. This reinforced the strong emphasis on improving access to education and employment opportunities, both within the hospital and in the community. Patients could access vocational and academic courses, plus basic skills such as numeracy and literacy. There were a number of opportunities for paid “real work”. Patients applied and were interviewed for these posts and received reimbursement for the work they carried out.

The provider sought carers’ views about the service annually and a local network facilitated carer involvement in the service. Staff supported contact with relatives and carers, and facilitated home and family visits. Skype was also available and staff had invested time in familiarising patients’ family members with Skype.

Listening to and learning from concerns and complaints

We saw that 18 formal complaints had been made in the 12 months ending on 31 August 2015. Six complaints were about loss or damage to property, one related to access to activities, two to staff attitude, two to staffing issues and the remainder to issues with other patients. Of these, two were upheld, nine were not upheld, one was transferred as it did not relate to the service and the remainder had been withdrawn. None were referred to the parliamentary and health services ombudsman. Each ward kept a log of informal complaints. We looked at 8 records and saw that complaints had been dealt with promptly.

The patients we spoke with said they knew how to complain or raise a concern and they were treated sensitively if they did so. We saw information on the wards about how to complain. There was a complaints officer who spoke with patients, investigated their complaints, kept them updated and provided feedback. The ward teams also received feedback and recommendations for improvements following the investigation of a complaint.

Rigorous and constructive challenge from patients was welcomed and viewed as a way of holding services to account. Complaints were dealt with openly and

Long stay/rehabilitation mental health wards for working age adults

Outstanding



transparently. Complaints and concerns were always taken seriously, responded to in a timely way and listened to. All the staff we spoke with were able to explain the complaints procedure. They told us that patients might make complaints formally or informally but the complaints process was always followed. Informal complaints were resolved at ward level.

There was active review of complaints and concerns and of how staff managed and responded to them. All complaints were raised at the daily handover meeting. They were reviewed at the weekly lead clinicians' meeting and stayed open until they were resolved. Patients were involved in the review via the patients' council.

Outcomes of complaints were communicated to staff via team briefings and individual supervision. Lessons learnt from complaints were addressed and communicated throughout the organisation. These were displayed in patient areas on "you said, we did" boards. For example, a "traffic light" system had been introduced to the daily menus so that patients had nutritional information for each option. Pro forma had been introduced to record storage and disposal of patients' belongings more accurately. Patient money sheets had been amended to incorporate printed staff signatures.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Outstanding



Vision and values

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

The corporate provider had adopted a set of values driven by quality and safety. The vision, values and strategy had been developed through structured planning with regular engagement from internal and external stakeholders, including patients, the people close to them, staff and commissioners. The corporate values were:

- valuing people
- caring safely
- integrity

- working together and
- quality.

There was a proactive approach to seeking out and embedding new and more sustainable models of care. For example, the service had adopted a further set of principles, called the 6Cs, alongside the recovery model. The 6Cs were developed in 2012 by the NHS Commissioning Board against a backdrop of concerns about standards of nursing care in England. They are:

- care
- compassion
- competence
- communication
- courage and
- commitment.

They were being used as a model of care alongside the recovery focused model.

We saw posters of the vision and values displayed and they were integrated into everyday business via team briefs, ward quality matters, quality accounts, "you said, we did", a quarterly carers' newsletter, good news stories, lessons learned and effective handover meetings. One ward manager was a care maker with NHS England. Care makers act as ambassadors for the 6Cs. The patients' council was represented at governance meetings.

Staff understood the vision and direction of the service they worked in at local level and about how their work linked into the vision and values. At each supervision session, managers expected staff to show how they incorporated them into their practice. Our discussions with staff and our observations of care being delivered assured us that the vision and values were embedded in the service and in individual practice. Staff commented that managers were extremely approachable and operated an "open door" policy for staff to raise any issues or concerns. They knew who the senior managers were and throughout our inspection we saw them acknowledging and speaking with each other. The patients we spoke with told us that staff were approachable and caring.

Good governance

There were clear governance systems to ensure the monitoring and management of services provided. Staff told us they had regular contact with the senior management team. They explained the leadership and

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Outstanding



management structures in their service and they knew who the senior managers were. There was a 'ward to board' model of governance that encouraged and supported staff to be involved in the governance process.

We found all the staff were well managed locally. Managers had the experience, capacity and capability to ensure that the vision and values could be delivered. Staff were clear about their roles and they understood the management structure. They received appropriate training and were appraised and supervised, complaints were investigated, incidents were reported and investigated, changes were made where needed and safeguarding and Mental Health Act (MHA) 1983 procedures were followed.

Governance and performance management arrangements were proactively reviewed and reflected best practice. Staff measured patient outcomes and clinical effectiveness.

On every ward, staff completed regular audits, monitored via electronic quality dashboards. Assessments, care plans and risk management plans were audited to ensure they were completed and reviewed regularly. There were also environmental audits that included ligature risk audits, and audits of infection control systems, equipment and medicines. We saw evidence that audit findings were addressed quickly.

All staff reported incidents using an electronic system; these were discussed every morning in the unit handover, which was attended by senior members of staff. There was evidence of staff learning from serious incidents, complaints and patient feedback. Across the teams, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Performance information was used to hold management and staff to account. Staff supervision was carried out at least every month. All staff had a supervision contract that set out both staff and provider expectations of supervision. Staff told us they had been supervised and appraised by their line managers and that they were supported by them as well as by their peers. We looked at records that supported this. The records we reviewed were all up to date.

Staff received mandatory training and had achieved 100% attendance by the time we inspected the service. Staff were

responsible for ensuring their training was up to date but their managers also monitored compliance. Throughout our inspection we discussed various issues with staff, such as safeguarding, mental capacity and dealing with violence and aggression, and we reviewed care records and supervision notes. We were assured that staff were competent and had the skills necessary for them to carry out their roles.

There was a good governance structure to oversee the operation of the rehabilitation service. Feedback from patients from annual surveys, ward quality matters, and patient-reported outcomes were used to inform and prioritise improvements in patient experience and care. There was a handover meeting every morning that all senior managers, ward managers and allied health professionals attended. All the wards held weekly team meetings where service level performance and wider issues were discussed. The ward managers reported to the governance team every week. This included information from patient community meetings and ward team meetings. We found the meetings we attended or saw minutes of to be well structured, informative and productive, addressing quality issues clearly. Ward managers told us they had sufficient autonomy to carry out their role and they felt supported by the senior managers.

Leadership, morale and staff engagement

Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. They made every effort to deliver and motivated staff to succeed. They actively shaped the culture through effective engagement with staff, patients and their representatives and other stakeholders.

Staff told us they felt well supported by their local managers, peers and more senior management. Many commented on the positive relationship they had with their managers. We saw clear examples of strong local leadership from the ward managers, such as implementing initiatives to meet the diverse needs of patients and ensuring the vision and values were embedded into individual practice and service delivery.

The leadership encouraged continuous improvement and there was excellent commitment to quality improvement across all the teams. Staff were motivated to deliver

Long stay/rehabilitation mental health wards for working age adults

Outstanding



change. Safe innovation was celebrated, for example, after staff had completed leadership training, managers encouraged them to develop a piece of innovative work to implement on their ward.

Staff had opportunities for career progression. Some health care support staff had been supported through training to become registered nurses. Staff support included a childcare scheme and a 24 hour helpline. Less conventional support for staff included relaxation sessions, whereby they could take half an hour out of their shift for a massage, and “working well”. “Working well” involved raffling prizes such as a spa day for staff.

Sickness and absence rates were low at 4%.

Leaders encouraged cooperative, supportive relationships among staff. Staff were proud of the organisation as a place to work and they spoke highly of the positive culture. They felt respected, valued and supported, and were positive about their jobs. They reported good multidisciplinary team working. Staff were supportive and caring towards each other. We observed all staff interacting as a cohesive team, with a clear understanding of others’ roles. They told us they enjoyed their work and were proud of the culture of care. They showed a clear commitment to providing the quality care that patients needed.

Candour, openness, honesty and transparency and challenges to poor practice were encouraged. Managers encouraged staff to be open and honest when things went wrong. The duty of candour was discussed at business meetings so that staff had a good understanding of the duty. Staff we spoke with understood what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Staff we spoke with at all levels of the organisation were actively encouraged to raise concerns.

Staff understood the whistleblowing process and said they would use it to escalate concerns. They told us they felt able to raise concerns without fear of victimisation, to promote service development and improvement.

There was a strong sense of shared decision making. Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers. Records we reviewed confirmed this.

There were annual staff surveys that showed high levels of satisfaction, with action plans for improvements based on the findings. There was a staff consultation meeting every quarter where service developments were discussed.

Staff could nominate colleagues who had impressed them by their practice. Local nominations took place every month. The site winner progressed to be considered for a regional award, then on for a national award. At the time of our inspection, one member of staff had just won the regional award for their work on dementia awareness.

Commitment to quality improvement and innovation

The leadership team at Kemple View were committed to quality improvement and participated in national quality initiatives.

There was a strong commitment to quality improvement and innovation from all staff at all levels.

There were plans for service improvements. A new, interactive system of supported self-management, PathNav, was being piloted that would support patients to plan their care pathway and have increased involvement in their own assessment, goal-setting, treatment and discharge planning. It was anticipated that this would increase levels of engagement with treatment and improve treatment outcomes. A further anticipated benefit was the reduced administrative burden on staff that would free up time to engage more with patients. Staff and patients were being trained in using the new system and there were patient “champions” who promoted it to other patients.

We also saw plans for a new development at Kemple View providing pre-discharge independent living accommodation for 24 patients. The plans had been developed in response to the difficulty in finding suitable placements for some patients and work was due to commence in March 2016.

Staff and patients were encouraged and supported to participate in quality improvement initiatives.

There were links with the University of Nottingham to develop service user involvement in the knowledge and understanding framework for personality disorder.

Kemple View had received an award for good practice for patient involvement in the annual “design in mental health” awards.

Outstanding practice and areas for improvement

Outstanding practice

The low secure service had been reviewed by the Royal College of Psychiatrists' quality network review team in April 2015 and fully met 95% of low secure standards, compared with a national benchmark of 81%.

Kemple View was recognised as a RAID centre of excellence. RAID is a recognised industry standard method of working with patients to help them manage their own behaviour, accredited by the association for psychological therapies. Being recognised as a RAID Centre of Excellence means that the organisation is implementing RAID principles outstandingly well.

There was excellent support for patients and their families in the use of technology. Skype facilities were available so that patients could more easily maintain their relationships with the people close to them, particularly where there was significant distance. As well as assisting patients, the service had invested time in familiarising patients' friends and families with the use of Skype.

Technology was used to help ensure that care and treatment was coordinated with other services and

providers. For example, tele- and video-conferencing were being used so that external care co-ordinators who might otherwise be unable to attend could contribute to care programme approach meetings. The use of projectors during care programme approach meetings ensured patients had the opportunity to comment on the report as it was written and enhanced their involvement in their care and treatment.

Patients were supported to attend community groups and activities; for example, neighbourhood groups, learning, vocational or volunteer opportunities. This reinforced the strong emphasis on improving access to education and employment opportunities, both within the hospital and in the community. Patients could access vocational and academic courses, plus basic skills such as numeracy and literacy. There were a number of opportunities for paid "real work". Patients applied and were interviewed for these posts and received reimbursement for the work they carried out.

Patients were involved in the review of complaints via the patients' council.

Areas for improvement

Action the provider SHOULD take to improve

The provider should:

- ensure that cleaning schedules are reviewed regularly
- ensure that arrangements for accessing the ward garden areas are reviewed regularly
- ensure all staff are aware of opportunities to reflect and learn.