

Good 

Nottinghamshire Healthcare NHS Trust

Forensic inpatient/secure wardsForensic services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Rampton Hospital	RHA04	Emerald, Blake, Alford, Evans, Ruby, Eden, Brecon, Grampian, Cheltenham, Erskine, Adwick, Juniper, Topaz, Anston, Newmarket, Kempton, Cotswold, Cheviot, Quantock and Bonnard	DN22 0PD
Arnold Lodge	RHAAR	Rutland, Helvellyn, Snowdon, Cannock, Ridgeway, Conniston, Tamar	LE5 0LE
Wathwood	RHARX	Continuing Care, Assessment and ICU, rehabilitation	S63 7TQ
Wells Road	RHANA	Porchester, Seacole, Thurland, Lister, Forensic community services	NG3 3AA

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for Forensic services

Good 

Are Forensic services safe?

Good 

Are Forensic services caring?

Good 

Are Forensic services effective?

Good 

Are Forensic services responsive?

Good 

Are Forensic services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The Forensic Service Division of Nottinghamshire Healthcare NHS Trust provides the following high, medium and low secure mental health services:

- High secure services – Rampton Hospital provides services for people who suffer from mental disorders and have dangerous, violent or criminal tendencies.
- Medium secure services – Wathwood Hospital and Arnold Lodge are purpose built medium secure facilities that provide inpatient mental health services for adults aged between 18 upwards.
- Low secure services – Wells Road Centre is an inpatient service for men and women detained under the Mental Health Act, and who have a mental illness or learning disability.
- Forensic community services – the Criminal Justice Liaison Team provides services for people with a mental illness and who come into contact with the criminal justice system. The Personality Disorder and Development Network is a community-based, group therapy service.

High secure services

During the inspection, we heard mixed views about the care and treatment at Rampton Hospital. However, we found that people who used the service viewed staff as caring, respectful and responsive. While most people accepted confinement at night and said they felt safe, some people did not like it and this was reflected in their care plans..

Some people were concerned about aspects of their care. When we brought these to the attention of the ward manager, they were already aware of the issues and told us how they were trying to resolve them.

People using the service and staff said that they felt safe, but people were worried that there were not enough staff. This had led to cancelled activities or events.

The environment was clean and welcoming, and there were systems and processes in place to monitor it. The standard of decoration was good, but some corridors needed minor repairs.

Care at the hospital met CQC national standards. There was an audit programme in place to monitor standards, and people and their carers were involved in planning and reviewing their care.

We were told, and we saw reports that showed, staff received appropriate training. This included night staff who spent time on day shifts to complete mandatory training. Most staff had received safeguarding training and were aware of the safeguarding processes. All staff said they could speak to their manager about their concerns, and said they thought these would be addressed.

Overall, the wards were well-led by the managers. However, we saw differences in how well wards were run, with some ward managers taking a stronger approach than others.

Medium secure services

The majority of services provided by the two medium secure hospitals (Wathwood Hospital and Arnold Lodge) were outstanding. However, we have rated services as 'good' in safety and responsiveness because there were blanket rules in place for the shop, and improvements were needed in the out-of-hours medical reviews of seclusion. This is the supervised confinement of a patient in a room, which may be locked. Its aim is to contain disturbed behaviour which is likely to cause harm to others (Code of Practice, 15.43).

Care at both sites was person-centred and was assessed, planned and delivered on an individual basis. People also had the opportunity to comment on the services, as well as have changes made. The care was recovery focused, and therapy and education were available to support this.

Staff morale was very high and the multidisciplinary teams worked well together. Staff were proud of the care they delivered. They also felt supportive of, and supported by, their colleagues, management and the trust.

The facilities were very good and were well-maintained, safe and secure.

Summary of findings

The services were safe and effective. There were clear reporting procedures and systems in place, which enabled staff to learn from incidents

Low secure and forensic community services

Although we heard mixed views about the standard of care at Wells Road during our inspection, overall people thought it was good.

The majority of people and staff said they felt safe, and people told us about the different ways in which they were encouraged to be involved in their care. However, some said that at times there were not enough staff, and that their care and treatment were affected as a result.

Staff told us that they attended a mandatory induction programme when they started working for the trust. The majority of staff also felt that they received a good level of professional development and that training was actively encouraged.

Summary of findings

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

Are services safe?

Across all sites, people who use the services said that they felt safe. There were systems and processes in place to ensure their safety, and the safety of staff.

We were told that there is an open reporting culture and a strong system in place for reporting incidents. We also saw staff newsletters that included information on lessons learnt from previous incidents. Safeguarding practices at all the hospitals were excellent. For example, we found that staff undertook risk assessments before people who use the services had contact with children, which was in line with hospital policy.

In the audits we looked at, we saw that there were systems in place to monitor cleanliness, and compliance with health and safety regulations.

However, we were concerned that medical reviews for people in seclusion were not happening quickly enough at Arnold Lodge. The trust has assured us that they have acted immediately to remedy this.

Good



Are services effective?

From our inspection, and talking with managers and front line staff, we found that people received care and treatment that was in line with current best practice guidelines. Care was focused on their recovery and their individual needs. There was also a range of therapies available. People told us that they had a good relationship with their doctors and the nursing staff.

The care, treatment and support that people received were based on the best evidence available, promoted a good quality of life and led to good outcomes. In addition, the medium secure services were part of the Royal College of Psychiatrists Quality network for Forensic Mental Health services.

There were systems in place to monitor the quality of care provided and to check that it met national standards. People's progress was also monitored by individual outcome measures.

Staff said that they felt well trained and equipped to carry out their roles. They also felt supported by both their colleagues and the hospital management.

The provider complied with the Mental Health Act, and mostly complied with the Code of Practice, except for medical reviews for people in seclusion.

Good



Summary of findings

Are services caring?

Overall, people who used the service described staff as caring and responsive and said that they felt safe. The care plans we looked at showed people were involved in reviewing their care and progress. We also saw examples where staff made adjustments to meet people's needs. Most people said their privacy and dignity were respected, and we heard staff speaking about people respectfully.

The way in which secure services involved patients was outstanding. Each hospital had a patient forum where issues could be raised. They also had carers' forums and organised carer days each year.

The secure services held, and reported on, regular community meetings. Generally, feedback about these meetings was positive, but some people felt that they could have been more regular.

Good



Are services responsive to people's needs?

There was an effective process in place for responding to complaints. However, the service needs to improve the way in which it feeds back to people about the outcomes of their complaints.

We saw, and were told by people who used the services, that their physical healthcare needs were met. We also observed that the different professional groups worked well together.

The medium secure services were willing to accept people on a trial basis, for example accepting people from a high secure hospital on section 17 leave, to see if it was a suitable environment. In addition, some people who had been transferred from prison were supported to return there if they wanted to.

While it was clear that care was delivered in line with individual needs, there were blanket rules in place at Arnold Lodge and the Wells Road Centre. For example, there was a limit on the number of items that people could buy from the hospital shop, but the provider had not completed individual assessments to determine if this was in everyone's best interests.

Good



Are services well-led?

There were processes in place for staff supervision and appraisals, which helped deliver safe and effective care. Staff confirmed that they had an annual appraisal and received regular clinical supervision. However, supervision from managers, and the recording of the supervision given, could be improved. Staff said that they felt well supported by their manager, and that they could raise any concerns and were confident that these would be addressed. The way in which the organisation was led focused on providing high-quality, person-centred care, and promoted an open and fair culture.

Good



Summary of findings

The people using services, and staff, had regular contact with senior members of staff, for example modern matrons. We saw in our focus groups with senior staff in the secure services that staff were dedicated to, and passionate about, their roles.

Summary of findings

Background to the service

High secure services

Rampton Hospital is a high security hospital because of the facilities and treatment it offers, and the people who use its services. These are people who suffer from mental disorders and have dangerous, violent or criminal tendencies.

On average, people stay in the hospital for approximately 7.5 years, but a very small number are likely to remain at the hospital for the rest of their lives.

Every person admitted to the hospital must fulfil two criteria. Firstly, they must be detained under one of the classifications of mental disorder, as defined by Section 1 of the Mental Health Act 1983. These are: mental illness, mental impairment, severe mental impairment and psychopathic disorder. Secondly, people admitted must need to be placed in a high security hospital. People thought to have either a personality disorder or a mental impairment must also be treatable.

We reviewed and inspected the services provided at Rampton Hospital, which form part of the trust's forensic services division. We visited 19 wards (Emerald, Blake, Alford, Evans, Ruby, Eden, Brecon, Grampian, Cheltenham, Erskine, Adwick, Juniper, Topaz, Anston, Newmarket, Kempton, Cotswold, Cheviot, Quantock and Bonnard), as well as the patients' shop, day centre and central resource office. We also carried out an unannounced night visit on four wards (Blake, Emerald, Anston and Evans) to look at confinement at night.

We examined the care records of 46 people and spoke with senior clinicians and other staff. We also met with 85 people who used the services, and went to multidisciplinary meetings and a community meeting.

Medium secure services

The trust's medium secure services are based at two sites: Wathwood Hospital and Arnold Lodge. These are purpose built facilities and provide inpatient mental health services for adults aged between 18 upwards.

Wathwood Hospital is based in Rotherham. Its services include acute admission wards, psychiatric intensive care unit, continuing care ward, rehabilitation ward and lodges. These are units that encourage people to become more independent.

Arnold Lodge is based in Leicester. Its services include an admissions and assessment ward including psychiatric intensive care unit for men with mental illness, two male rehabilitation units, and two male personality disorder units. The service also provides women's standard and enhanced medium secure units.

Low secure services

Wells Road Centre is a low secure inpatient service. It provides care and treatment for men and women who are detained under the Mental Health Act, and who have a mental illness or learning disability.

Prospect House is a pre-discharge unit which provides 'step-down' care from low secure hospitals. Its purpose is to help people to return to the community.

Forensic community services

The Criminal Justice Liaison Team provides screening, assessment and advice for people with a mental illness who come into contact with the criminal justice system.

The Personality Disorder and Development Network is a community-based, group therapy service for people with either a confirmed diagnosis of personality disorder, or who have personality disorder traits which are negatively affecting their life. There are plans for the network to end later in 2014.

The city and county community forensic teams manage and treat people with a mental illness or personality disorder who have a history of harming others. The teams also offer advice to other services/professionals and provide a range of specialist assessments.

Our inspection team

Our inspection team was led by:

Summary of findings

Chair: Dr Paul Lelliott, Deputy Chief Inspector Hospitals (Mental Health and Substance Misuse), Care Quality Commission (CQC)

Team Leader: Jenny Wilkes, Interim Head of Inspection, CQC

The team included: a CQC mental health inspector, consultant forensic psychiatrist, specialist advisor in patient advocacy, Mental Health Act Commissioner,

specialist advisors in mental health nursing, specialist advisors in occupational therapy, specialist advisor in learning disability nursing, specialist advisor in psychology, and a student nurse.

The team also included an Expert by Experience who had personal experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited the Forensic Services Division of Nottinghamshire Healthcare NHS Trust on 29, 30 April

and 1 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors, and therapists. We talked with people who use services, their carers and/or families. We observed how people were being cared for and reviewed their care or treatment records

What people who use the provider's services say

Rampton Hospital

People told us that most staff were respectful and caring at Rampton Hospital.

Some people said that they had missed activities and access to fresh air, or that activities had been cancelled, because there were not enough staff. However, other people told us they had plenty to do throughout the week, and that there was a variety of activities available.

Most people told us that they felt safe, but some did not being locked in their bedrooms at night. People also said that their physical health was looked after well.

Everyone we spoke with told us they had help from advocacy services when it was needed, and that their relatives were involved where possible.

However, some people told us that they had concerns about their care, which we brought to the attention of the ward manager.

Wathwood Hospital and Arnold Lodge

People who used services at Wathwood Hospital and Arnold Lodge told us that they felt safe and well-cared for at both services. They also felt that they were listened to and were supported to have a say in how the hospitals were run.

Summary of findings

People had regular contact with their psychiatrist and good access to therapies. They were also positive about their relationships with the staff and the attitude of the staff. People said they contributed to their care plans and that staff at all levels listened to them.

Good practice

Rampton Hospital

In all the services, we saw good examples of the approach taken to people's care. This was also reflected in care plans and in feedback from people using services. In particular, the learning disabilities service stood out as an example of excellent practice, and encouraged independence and rehabilitation at a lower level of security.

We observed, and saw evidence of, good multidisciplinary working across all wards in the hospital.

Psychology services were available for the whole hospital. Although psychological therapy was offered to everyone, some people refused it. We found that people's progress is linked to their attendance at individual and group therapy sessions.

Wathwood Hospital and Arnold Lodge

We saw examples of outstanding practice across both medium secure units, with people who used services involved in their care. The multidisciplinary teams at both hospitals worked well together and there was an open culture for reporting incidents.

At Wathwood Hospital, we saw that each ward had a place for staff, known as the 'hotspot', which had line of sight from all areas of the ward and was permanently occupied by a member of staff. This contributed to safety on the ward. Wathwood Hospital used information technology and laptops well so that staff could spend more time on the ward.

The quality of the women's services at Arnold Lodge was high quality. In particular, we noted that the seclusion area was used positively to help women feel safer.

Wells Road and Forensic Community Services

The compassion of staff working within the Personality Disorder and Development Network was excellent. Given that many people with a personality disorder often face difficulties in accessing services, we were impressed that the service allowed people who use services, as well as professionals, to refer themselves for help. We felt the team worked well together and shared sense of purpose, which was both person-centred and focused on people's therapy.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The trust must ensure the welfare and safety of patients at Arnold Lodge by means of appropriate arrangements for four hourly medical reviews of patients in seclusion.
- The trust must ensure there are arrangements in place to ensure reviews take place in line with the Mental Health Act Code of Practice at Arnold Lodge.

Nottinghamshire Healthcare NHS Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Emerald, Blake, Alford, Evans, Ruby, Eden, Brecon, Grampian, Cheltenham, Erskine, Adwick, Juniper, Topaz, Anston, Newmarket, Kempton, Cotswold, Cheviot, Quantock and Bonnard	Rampton Hospital
Rutland, Helvellyn, Snowdon, Cannock, Ridgeway, Conniston, Tamar	Arnold Lodge
Continuing Care, Assessment and ICU, rehabilitation	Wathwood
Porchester, Seacole, Thurland, Lister, Forensic community services	Wells Road

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.

We found that all staff understood the application of the Mental Health Act (1983).

Adherence to this was good across all services with the exception of Arnold Lodge where there were concerns about the lack of out of hours doctor cover and the lateness of medical reviews for secluded patients.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that nursing staff and managers had a broad understanding of the Mental Capacity Act in secure services. Staff attended training to ensure that they had the requisite knowledge and this training was completed as part of the mandatory trust training.

Are services safe?

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

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

Summary of findings

Across all sites, people who use the services said that they felt safe. There were systems and processes in place to ensure their safety, and the safety of staff.

We were told that there is an open reporting culture and a strong system in place for reporting incidents. We also saw staff newsletters that included information on lessons learnt from previous incidents. Safeguarding practices at all the hospitals were excellent. For example, we found that staff undertook risk assessments before people who use the services had contact with children, which was in line with hospital policy.

In the audits we looked at, we saw that there were systems in place to monitor cleanliness, and compliance with health and safety regulations.

However, we were concerned that medical reviews for people in seclusion were not happening quickly enough at Arnold Lodge. The trust has assured us that they have acted immediately to remedy this.

members of staff received training in safeguarding children. Staff told us about systems in place to ensure people were not bullied by other people into giving away their money or belongings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff were alert for signs of abuse or exploitation. The risks of and management of bullying was taken very seriously and staff ensured people had opportunities to speak up. We spoke with people on Cannock Ward who shared an anti-bullying programme they had developed. They had been supported by the consultant and other members of staff in developing this and were undertaking training in facilitation. People using services would then deliver the programme to other people who use services within the hospital.

All relevant staff received training in managing violence and aggression on induction and had regular updates. Both people and staff told us they felt safe. Rules and boundaries within the hospital were very clear and explicit. For example on Cannock Ward a list of all rules and boundaries was available to both people and staff. On Cannock Ward we noted that window catches were a ligature risk and in order to reduce and manage this risk cameras had been installed to cover the corridor. On both Cannock and Ridgeway Wards there was a zero tolerance to violence and people who were violent would have to transfer to either another ward or back to prison.

There were two women's wards in the hospital and staff ensured that these areas were not accessible by male people who used services. Coniston Ward was in the newest section of the hospital. It had been designed, with people's involvement, to be light and airy whilst posing minimal environmental risk. Women on both Coniston and Tamar Wards were very complimentary about the safety of the ward and the responses by staff to their distress.

Assessing and monitoring safety and risk

As a medium secure hospital Arnold Lodge had robust security systems in place to ensure only authorised people entered and exited the hospital. There was no admittance without correct identification. Movement around the site required a set of keys. All staff wore alarms to enable them to summon assistance rapidly.

Our findings

Arnold Lodge

Track record on safety

There was an effective system in place for reporting of and learning from incidents. Staff, at all levels, were able to tell us about the incident reporting process. Following the reporting of an incident the ward manager would complete an analysis of the incident and identify any learning. Staff told us that they would receive feedback about outcomes of, and learning from, incidents. Staff said there was an open culture and they were confident in reporting incidents. They also felt that it was safe to admit to making a mistake. Staff we spoke with had been trained in safeguarding vulnerable adults from abuse and were able to tell us about reporting procedures. Additionally all

Are services safe?

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All people using services had thorough risk assessments and staff were conscious of both individual risk and risk overall within the hospital. Relational security throughout the hospital was effective with staff having a clear understanding of the need to balance security with a therapeutic environment.

We were concerned that there were no suitable arrangements in place to ensure the hospital had sufficient and appropriate access to on-call doctors out of hours. A seclusion audit reported in November 2013, which used more lenient timescales than those within the Code of Practice, found that:-

- 50% compliance with first medical review within 30 minutes of seclusion.
- 30% of four hourly reviews were late.
- 50% of multi-disciplinary reviews were within the prescribed timeframe.
- Only 14.61% of entries contained all essential data.

We were also concerned that some of the on-call doctors (who normally did not work for the trust) did not have RiO logins. As a result they could only make clinical entries using logins of nurses on duty. As a result these entries would only be recorded under nursing notes.

We asked what actions had been taken in response to these findings and were told that there were two. A proforma had been developed for doctors to fill out on RiO after each review but this had not been actioned as it needed to be discussed but the Health Informatics group. It was discussed in March 2014 and again in May 2014. A notice has been placed in seclusion areas reminding doctors of what they should cover during a review.

Consultant Psychiatrists working at the trust confirmed that they were concerned about the lack of out of hours doctor cover and the lateness of medical reviews for secluded patients. They felt that it was unsafe and not compliant with the Code of Practice. The clinical director for Arnold Lodge told us that there were competing priorities for out of hours doctors and that if the doctor is going to be late due to seeing a more urgent patient, "I am content with that". Then if the patient is asleep later on the nurses might let it go overnight before the patient has a medical review".

We asked if the clinical director considered this to be a deviation from the Code of Practice, if so did he feel that they had a cogent reason for doing so. We also asked if this

had been agreed within the governance structures of the trust. He replied that it had not been agreed as the board let them make their own sensible clinical decisions and he did not feel this was a risk. He further stated, "There is no evidence that a four hourly review by a medic is less risky than a four and a half hourly review or a five hour review. These review timings are not evidence based".

Understanding and management of foreseeable risks

There was a system within the hospital for staff to be 'borrowed' from other wards if additional staff were needed. There was insufficient out of hour's doctor cover, with on-call doctors often arriving late or not at all. For example one duty doctor was pregnant and therefore could not enter the ward environment to see a person who used services. Clinical staff acknowledged that the issues with on-call doctors were known.

We were told that if doctors were late, or did not attend, this would be reported as an incident. We checked the electronic risk management system, and there was no record of any late/missed doctor visits. The trust did not have a system in place to manage the risks associated with the late or non-attendance of on-call doctors.

Wells Road and Community Forensic Services Track record on safety

People who used the services stated they felt safe on the wards and whilst in the care of staff, although staff advised that there had been incidents where staff had been assaulted. We observed people on the ward appearing to be content with those providing care. Staff were aware of their responsibilities in raising safety incidents. Mechanisms were in place for staff to be able to report any safety incidents and staff reported receiving support, by means of debriefing, following significant incidents. Staff felt satisfied with regards to how managers dealt with incidents when they were raised. Examples of different reporting mechanisms were ward business meetings, during their supervision or directly with the ward manager or service manager. Staff told us that less experienced staff would be supported and assisted in raising incidents and in the use of the incident reporting system. We saw numerous incident reports having been appropriately raised where people's safety may have been compromised. Staff also

Are services safe?

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received feedback about incidents which occurred by email. Community staff also explained that there was a debrief process in place and they could refer to staff counselling services if required.

Learning from incidents and improving safety standards

Staff felt they received adequate feedback from when incidents had occurred enabling them to learn and make changes, where necessary, to their practise. Such lessons learnt from when incidents had occurred were emailed to staff and staff felt any necessary improvements and changes to practice were made. Despite this, when we asked some senior staff to describe to us examples of where changes had been made in response to incidents, they struggled to outline these. We saw evidence of serious untoward incidents being discussed within the Directorate Management Meetings and saw examples of action plans which had been developed to learn from incidents which had occurred.

Staff we spoke with felt management responded to incidents and any concerns seriously and could be approached.

Community staff stated that appropriate assessment processes were in place as well as risk assessments which were being done to collate the risk. They also had a robust procedure in place should people need a service out of hours.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had received training with regards to safeguarding. This consisted of both face to face and 'e-learning.' Safeguarding training was mandatory and took place at the point of induction and refresher training was provided on a regular basis. Staff told us that they received periodical training with regards to safeguarding. Managers would oversee staff's attendance at such training to ensure it was completed. This was then monitored by managers.

We became aware that a safeguarding concern had been previously raised with regards to a person who used the service at Prospect House, but when we asked staff what had happened following the safeguarding referral they did not know.

One of the managers we spoke with was not aware of whether a whistleblowing policy was in place.

Although no audits of safeguarding incidents were being carried out specifically by Prospect House, we saw safeguarding incidents were being considered within the Directorate Management Team meetings

People who used the service gave us examples of how ward staff helped to keep them safe. For example, staff would monitor the forecourt area to help prevent trading and swapping of possessions taking place. This meant the risk of some of the more vulnerable people on the ward from being exploited was being reduced.

The PD network reported lower numbers of safeguarding than the community forensic teams, but all were aware of reporting systems both internally and to the local authority. They were also able to demonstrate good links with the Multi-Agency Public Protection Arrangements (MAPPA) process.

Assessing and monitoring safety and risk

Wells Road is a low secure unit and as such had robust security systems in place to ensure only authorised people entered and exited the hospital. There was no admittance without correct identification and movement around the site required the use of keys. All staff wore alarms to enable them to summon assistance rapidly.

All people who use services had thorough risk assessments and staff were conscious of both individual risk and risk overall within the hospital. Relational security throughout the hospital was effective with staff having a clear understanding of the need to balance security with a therapeutic environment. Section 17 leave was monitored and risk assessed.

We received mixed feedback about staffing levels with some staff describing them as being "usually good" whilst others reported staff shortages. Generally however the majority of staff, and people who used the service, felt staffing levels on the ward were adequate. We were told that where additional staffing was needed they did not use agency staff but used either their own staff as overtime or the trust's bank system. This was to help with continuity of care and reduce the numbers of different staff which people who used the service were required to work with.

We had concern regarding people who used the service being restricted in the amount of snacks and treats which they could buy from the unit's coffee bar. Numerous people told us about this restriction and several staff confirmed limits were in place. We observed a person who used the

Are services safe?

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service getting agitated in the coffee bar because they were not being allowed to buy more than what the unit's rules allowed. One staff member told us the limit had been imposed to help avoid people putting on weight, especially given some of the medications people were on could cause weight gain. Another staff member told us the restrictions of snacks/treats were a balance between people's mental capacity and the hospital's duty of care.

Whilst recognising these are difficult and contentious issues, mental capacity law is clear in that people who have the mental capacity to make a particular decision, in this case about what to eat and not eat, are allowed to make unwise decisions even if it is detrimental to their health and well-being. Similarly, mental capacity law is clear in saying that a diagnosis of mental illness does not automatically mean a person is not able to make some decisions for themselves. Accordingly, it was our view that the imposition of a blanket rule which applied to all people who use services was a form of restrictive practice as referenced in the Code of Practice. This was because the rule was not based on and did not consider the mental capacity and risks of individual people who used the service.

A further issue raised consistently within the unit were the rules in place for people who used the service using mobile phones. Both people who used the service, and staff we spoke with, told us that people could only use a mobile phone under the supervision of staff at set times. Numerous people told us this observation often took place on a group basis, meaning all people on the ward would be brought together to use their mobile phones, whilst staff observed. Several people told us they felt uncomfortable

with this as it meant both staff, and other people, could overhear their conversations which may be personal. People using services were aware of ward pay phones but there was consistent feedback about how much they cost, which was usually much more expensive than mobile phone calls.

A process was in place to assess and manage the transfer of people from low secure environments to Prospect House and other environments. We saw how all people who used the service were on a minimum of general observations so that any potential risks could still be managed by the service.

Community staff stated that appropriate assessment processes were in place as well as risk assessments which were being done to collate the risk. The PD network had an open referral system and a weekly meeting to discuss all referrals.

Understanding and management of foreseeable risks

There was no policy or process in place for Prospect House regarding how any controlled drugs were managed. When we asked staff how they managed a person's controlled medication, they did not know.

People who used the service were enabled to take their own regular medications but the amount of medication they were given was limited to a week's supply. This helped to manage any potential risks to people who used the service and safeguard them from harm. Medication charts had people's photographs attached to them, reducing the risk of giving medication to the wrong person.

Are services effective?

Good 

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

Summary of findings

From our inspection, and talking with managers and front line staff, we found that people received care and treatment that was in line with current best practice guidelines. Care was focused on their recovery and their individual needs. There was also a range of therapies available. People told us that they had a good relationship with their doctors and the nursing staff.

The care, treatment and support that people received were based on the best evidence available, promoted a good quality of life and led to good outcomes. In addition, the medium secure services were part of the Royal College of Psychiatrists' Quality network for forensic mental health services scheme.

There were systems in place to monitor the quality of care provided and to check that it met national standards. People's progress was also monitored by individual outcome measures.

Staff said that they felt well trained and equipped to carry out their roles. They also felt supported by both their colleagues and the hospital management.

The provider complied with the Mental Health Act, and mostly complied with the Code of Practice, except for medical reviews for people in seclusion.

All people using the services reported they could access physical healthcare when needed. They said, and we saw, they had access to a physical health doctor and/or a nurse practitioner when required. Assessments included physical healthcare needs.

Improvements could be made in the recording of capacity assessments and informed consent.

Outcomes for people using services

Outcomes were identified during the planning process to encourage people who used the service to move through the treatment pathway. These outcomes were appropriate for the type of services provided at Rampton. Psychometric testing and risk assessments were used on a regular basis and recorded. People we spoke with could tell us what they needed to do, to move on, either to another ward or a unit outside, for example a medium secure unit.

Staff, equipment and facilities

Staff we spoke with told us they had received a comprehensive induction and received mandatory training on a yearly basis. Staff reported they could access specific training to support their role, for example training on personality disorder or cognitive behavioural therapy (CBT). Staff were trained in schema therapy - which is person oriented and CBT which focuses on problems.

We saw reports on compliance against mandatory training. The latest report showed Rampton at a high compliance level. Permanent night staff attended training during the day to comply with mandatory training requirements. We were told by senior managers that internal rotation was being introduced where staff worked days and nights on a rotation basis throughout the year. This was not yet fully implemented.

Care and treatment was in line with NICE guidelines within psychology although staff told us this service was to be cut by 38%. This will impact the capacity to deliver psychological therapies and the trust should assess the impact of this on the quality of care provided. Reports also showed appraisal rates at a high level and staff told us they received an annual appraisal. All staff said they received clinical supervision and we saw records of this happening. Managerial supervision was reported as being less frequent and records of this were scant. Improvements could be made in provision of managerial supervision. We saw action was taken to address poor performance.

Our findings

Rampton Hospital

Assessment and delivery of care and treatment

From the evidence inspected and discussions with managers and front line staff, we saw the trust was able to demonstrate people who used this service received care and treatment in line with the current best practice guidance. Care plans were developed with involvement from people using the service and were regularly reviewed and updated. National guidance was reviewed and audited in relation to service compliance, for example against National Institute for Health and Clinical Excellence (NICE) guidance.

We saw an example of planning for one person who was expected to return from another hospital for end of life care.

Are services effective?

Good 

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We were also told about the staff awards process for rewarding good practice.

In the newer parts of the hospital the facilities and décor supported a therapeutic environment, but this was less evident in the older parts. For example intercoms were available in people's bedrooms, and seclusion rooms in most areas, but there were some areas where intercoms were not installed and staff and people reported they spoke through the hatch and shouted to communicate. This had a negative impact on privacy and dignity. Improvements could be made in the availability of intercoms in these areas. Not all seclusion rooms had en-suite facilities.

Although in one ward, in the older part of the hospital, the ward manager had allowed people who use services to be involved in decorating the ward and had replaced the furniture to make it more comfortable. This made the ward environment pleasant and welcoming.

There were interpretation services available and we accessed a signing interpreter when we spoke with people in the deaf services.

We saw there was a shop where people could purchase a wide variety of foods, magazines and a small range of clothing.

Multidisciplinary working

When we looked at care records we saw care plans were comprehensive and included input from all professionals involved. We attended multi-disciplinary meeting and observed good communication across professionals. People who used the service told us they met with social workers, psychologists and other health professionals when needed. When a move to another was planned the records showed good communication between the two services.

Mental Health Act (MHA)

We saw in the records people were told about their rights under the Mental Health Act (1983) and this was regularly re-visited and recorded.

Of the 12 medicine cards we checked we noted two drugs had been prescribed without the correct authorisation. This was pointed out to the ward manager for immediate action. We found one T2 (Consent to treatment) form which had been signed by the previous Responsible Clinician (RC). This was reported for immediate action.

Records did not always show discussion between the Second Opinion Appointed Doctor (SOAD) and the other professionals with whom they were expected to consult. There was not always a record of the outcome of the SOAD visit being discussed with people.

We spoke with one person who was unhappy with their medication and we asked for a SOAD visit to be arranged as soon as possible.

We were made aware by staff on one ward that there had been no RC on the ward for the last two weeks owing to the previous locum consultant leaving.

We have concerns about failure to follow the MHA Code of Conduct and improvements should be made in this area to ensure compliance with the MHA Code of Practice.

Wathwood

Assessment and delivery of care and treatment

The hospital delivered care and treatment in line with best practice. Staff used nationally recognised rating scales to assess and manage risk.

We saw that the hospital had implemented the Productive Mental Health Ward system which we were told had improved efficiency.

We saw that, where needed, mental capacity assessments had taken place. For example people's mental capacity was assessed if staff were concerned about potential financial abuse, or other issues which may make them vulnerable.

Comprehensive assessments were carried out and we saw people were assessed before being admitted to the hospital and clear care and risk plans were in place. Plans were holistic and covered people's vulnerability as well as their risk to others.

People within the ward were at high risk of violence, aggression and self-harm and care plans reflected this. People we spoke with confirmed they knew about their care plans and that staff had involved them in discussion. The provider may wish to note that there was only a very small space on care documentation to record people's views of their care plan. People were supported to be involved as much as possible, both in their own care, and in the wider running of the hospital. People were involved in care program approach (CPA) meetings and took part in ward rounds. People we spoke with knew where they were in their treatment and spoke with us about their future. For example one person had chosen to leave the hospital and

Are services effective?

Good 

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

return to prison, whilst another told us about their planned move to the rehabilitation ward. A third discussed their medicines with us. They told us about their current medicines, that they had not got on well with their previous medicine and had been able to discuss this with their consultant.

We observed staff discussions in handover where people who use services were discussed individually. Staff considered capacity when deciding on leave and family visits. For some people staff felt family could exacerbate their mental health problems, however, if it was important to the people that these visits were facilitated in a safe manner.

There was a physical health suite in the hospital which included a dental surgery. GP care was provided by a local GP within the hospital and health care was available from registered general nurses.

Meals at the hospital were calorie controlled and menus were designed to keep people's weight stable whilst also providing choice. A light lunch was available and an evening meal, both with vegetarian options. A takeaway was provided on Saturday night which people could choose, but one option had to be halal. We were told that cultural meals were available.

Every two months the hospital had a Caribbean night and food was provided by an external caterer. Additionally events such as Eid were celebrated and culturally appropriate food served. People who use services told us that they liked some of the food, but not all of it.

Outcomes for people using services

Wathwood was voted best medium secure unit in the country by the Quality Network, a peer review system facilitated by the Royal College of Psychiatrists. Wards had individual dashboards which contained data in respect of targets, such as care planning and CPA meetings, which helped ensure that outcomes were being met.

Staff, equipment and facilities

Staff morale was high and every member of staff was positive about working at the hospital. We noted consistent themes in regard to individualised care, flexibility and people's involvement. Staff spoke of feeling supported and empowered and spoke highly of the management team. Staff felt there was a high level of support and that training and supervision were available and effective.

There was a therapies team consisting of psychologists, a psychotherapist and occupational therapists. A range of treatment, both individual and group, was available which were provided on the basis of individual need. Therapies available included emotional regulation, cognitive analytical therapy, anxiety management and CBT. Occupational therapists provided groups with different themes such as music, creative activities and work placements in the shop, library and restaurant.

We were shown around the hospital by two people who spoke very positively about the facilities and environment of the hospital. People who use services could access a well-equipped gym and there was a swimming pool. We were told that even if people required several members of staff to support them they would have access to the pool. People who use services had access to a library with supervised internet access (they were registered with the library on admission). We saw a well-equipped crafts room which people could access with one person stating they spent most of their time in this room.

There was a physical health suite which included a dental surgery.

The hospital had a small farm with some animals and a poly-tunnel for growing plants. There was a farm shop, staffed and run by people who use services, with staff support. The hospital also ran a restaurant which people using the services had chosen to call, "Section 17". This was a working restaurant and people could work in both the kitchen and restaurant. Families, carers and other visitors were able to eat there and the restaurant had won an award.

Multidisciplinary working

All the staff we spoke with told us that there was a multidisciplinary approach. We saw that ward rounds and CPA meetings had input from the professionals involved in people's care and that decisions were made using the MDT approach. Documentation in people's records demonstrated that professionals involved in people's treatment had prepared reports and contributed to the process. We observed CPA meeting and ward rounds and saw them to be thorough and of good quality.

There were social workers, from the local authority, based within the hospital who carried out liaison with families and external agencies and were involved in ward rounds.

Are services effective?

Good 

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

Mental Health Act (MHA)

The hospital was compliant with the Mental Health Act 1983 (MHA). We found that the assessment of people's capacity to consent to medicines was not recorded in their notes, however we were satisfied that discussions took place. Visits by Mental Health Act commissioners in the year preceding our inspection had found overall compliance with the MHA, but had identified some recording issues in respect of medicine consents.

All people in the hospital were detained under the Mental Health Act 1983. All of the records we looked at evidenced that people who use services were detained lawfully. Overall the hospital was meeting the principles of the Mental Health Act Code of Practice

Arnold Lodge

Assessment and delivery of care and treatment

People who use services were supported to be as involved as possible both in their own care and in the wider running of the hospital. People were involved in care programme approach (CPA) meetings and received feedback from ward rounds. Those we spoke with were aware of where they were in their treatment and told us about their future. The majority of people we spoke with felt they were supported appropriately and had therapeutic relationships with the staff. All the staff we spoke with demonstrated a person-centred approach where people were at the centre of their care.

Handovers were clear and individual people and risks were discussed.

Women using services on the two women's units said they were involved in their care plans and supported by staff to participate in their CPAs. There was access to advocates and people felt listened to. One woman told us, "Staff actually go through my care plans with me. I can dictate what's in it". They said they had been supported to make a personal statement about seclusion and that, "People never helped me before".

Records demonstrated that assessments had been carried out prior to admission and risk assessments completed. There was evidence of social work input to support people's access to their families. Where there were restrictions on certain items we saw that this was included in their care plan.

Men using the services, on the personality disorder units (PDUs), told us they were listened to and involved in their

care. During our visit we saw one person preparing for their CPA meeting and we were told that people who use services had a very high level of involvement in CPA meetings. One person on this unit told us they did not want to stay on the unit and staff had arranged for them to return to prison. This person was not happy on the unit; however other people who use services were positive and told us they felt they received a good level of care.

People were supported to remain in contact with families and there was a dedicated space for visits to take place along with a dedicated family suite available. A thorough assessment was carried out by the hospital, including social work staff, prior to arranging child contact and all visits took place in the family suite under the supervision of appropriately trained staff.

There was a physical health suite in the hospital which included a dental surgery. GP care was provided by a local GP within the hospital and health care was available from registered general nurses.

Outcomes for people using services

Arnold Lodge was part of the peer review system facilitated by the Royal College of Psychiatrists.

Staff, equipment and facilities

Staff morale was high and every member of staff was positive about working at the hospital. We noted consistent themes in regard to individualised care, flexibility and people's involvement. Staff felt supported and empowered and spoke highly of the management team. Staff stated there was a high level of support with training and supervision available and effective. It was evident from speaking with staff that teams were cohesive and mutually supportive.

The consultant psychiatrist group reported that they valued working in Arnold Lodge, felt supported by management and were satisfied with the care they delivered. However two of the consultants expressed concerns that the current cost improvement programmes were having an impact on the quality of care and they were worried this may eventually affect the safety of people who use services.

Staff told us that there was a thorough induction and they felt very safe and supported.

We spoke with two staff that compared Arnold Lodge very favourably with other places they had worked.

Are services effective?

Good 

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

There was a therapies team consisting of psychologists, a psychotherapist and occupational therapists. A range of both individual and group activities were available. Some of the activities on offer were yoga, gym as well as creative activities. Motivational work was carried out with people who found it difficult to engage.

Therapies were available, based on assessed need, and were a combination of group and individual work. Some of the therapeutic treatment available included anger control, substance misuse and the violent offender's treatment programme. People receiving treatment for sexual offending received this individually. Occupational therapists provided groups with different themes such as thinking differently, creative activities, social skills and work placements in the shop.

There was a structured programme of activity for the male mental illness wards which included exercise and education. Some people on these wards said there was not a lot to do as they did not want to participate in groups. However other people were more positive and said there was lots to do and they enjoyed the structure.

Some staff told us that there was often an issue with escorted ground leave, as members of the team could be called away to support staff on another ward, which was unsettling. People who use services told us that leave could sometimes be cancelled due to lack of staff.

Multidisciplinary working

All the staff we spoke said that there was a multi-disciplinary approach. We saw that ward rounds and CPA meetings had input from the professionals involved in people's care and that decisions were made using the MDT approach. Documentation in people's records demonstrated that professionals involved in their treatment had prepared reports and contributed to the process. We observed CPA meeting and ward rounds and saw them to be thorough and of good quality.

There were social workers within the multi-disciplinary team who carried out liaison with families, external agencies and were involved in ward rounds.

The psychology department were involved in multi-disciplinary team meetings and were available, not only to assess the clinical needs of people who use services, but to provide support for staff teams as a whole and staff individually.

Mental Health Act (MHA)

The hospital was compliant with the Mental Health Act 1983 (MHA).

We noted good practice in the use of seclusion by Coniston Ward. People who use services could be isolated, or request to be isolated in a low stimulus area, but still have access to outside space or have staff with them. Post restraint/seclusion reviews were held and positive behaviour plans put in place as a result. The ward manager told us that seclusion was used when people's mental state deteriorated rather than because they were angry with the staff.

All those using services in the hospital were detained under the Mental Health Act 2003. All of the records we looked at evidenced that people were detained lawfully. The hospital was meeting the majority of the principles of the Mental Health Act Code of Practice, apart from the recording of seclusion and the timeliness of medical reviews, particularly from on-call doctors (see Safe domain).

On Rutland Ward there was poor recording of seclusion for one person secluded from 3 March to 30 May 2014. Neither the seclusion records nor electronic person notes indicated that seclusion was necessary. Random sampling of records during the period stated the person was settled and calm. The reviews of seclusion did not accurately explain why seclusion continued. Staff were able to explain the reasons for the seclusion, and its continuation, but agreed this was not recorded in the clinical record. They told us they did not have time to write accurate and complete clinical records of the interventions used.

Wells Road and Community Forensic Services Assessment and delivery of care and treatment

Staff we spoke with told us where policies and procedures were kept ensuring care and treatment was given in line with both local and national guidance. Staff told us there was an expectation that they were required to read, and sign to confirm their reading, of a policy once a month. Staff also told us this was checked by managers to ensure it had been done.

There was evidence of a range of activities which were made available to people who used the service.

During a ward round which we observed, we saw evidence of physical health care for a person who used the service being appropriately considered.

Are services effective?

Good 

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

We saw examples of assessments which had been carried out in relation to people's care. For instance, staff carried out assessments based upon the Model of Human Occupation Screening (MOHO) to gain a sense of a person's strengths, and areas for development, in day to day living and activities. We saw individual care plans had been devised to meet people's assessed needs.

We found examples where good and effective communication had taken place between different wards and where comprehensive care plans had been written.

From the evidence inspected and discussions with managers and front line staff, we saw the trust was able to demonstrate people who used this service received care and treatment in line with the current best practice guidance.

Community teams report good multi-disciplinary and multi-agency working and are also trialling weekends to provide a fuller service.

Outcomes for people using services

People told us they received a good level of input from a GP to ensure any physical health needs were both assessed and treated. During a ward round, which we observed, we saw the physical health care needs of a person who used the service being considered. Staff told us people who used the service were seen by physical healthcare nurses to make sure any physical health needs were being addressed. We saw care records which confirmed this. One person spoke of how they had accessed dental services, with ease, ensuring dental care was met. Staff we spoke with confirmed the use of local dental services for people on the ward.

One person from Prospect House agreed to speak with us. They described the unit as being "pretty good".

We found examples where good and effective communication had taken place between different wards and where comprehensive care plans had been written.

Staff, equipment and facilities

Staff in both inpatient and community settings described having been required to attend an induction programme when they started work for the trust. The majority of staff felt they received a good level of professional development and training was actively encouraged. One member of staff said, that in their experience, if a staff member had a particular interest in a specific issue the trust would try to

facilitate their training/education. Another senior staff member said they had "no problems getting training" and that they had never been refused a training request. Staff who did not have a professional registration shared a sense of frustration regarding what they considered to be limited opportunities for their development. It was the view of these staff members that they would often be overlooked when it came to more formal training opportunities.

The medical staff who worked at The Wells Road Centre were specialists in the subject of forensic psychiatry and learning disability. The centre only had senior grade psychiatrists given the specialist nature of the work.

Staff at Prospect House had specific knowledge and experience of working with people who have mental illness and forensic histories. We were told by several staff about how the 'Management of Violence and Aggression' training throughout The Wells Centre, including Porchester Ward, was now carried out onsite instead of at the high security hospital, Rampton. Several staff, from across the units, felt this had resulted in the training being much more relevant to the needs of people who were cared for in a low secure setting.

Staff from Seacole Ward provided us with examples of quite specific, specialist training which staff had received. Examples of such training included working with people who self-harmed, recognise 'relapse signatures' (which are signs a person may have a tendency to show when they are starting to become, for example, unwell or aggressive) and 'mindfulness'.

Multi-disciplinary working

We attended and observed a ward round taking place. Whilst we saw there was representation of different professions, this range was limited to a consultant psychiatrist, staff nurse, occupational therapist and secretary. We were told that psychology input to one ward round was intermittent, however this varied from ward to ward. There was also no dedicated social worker within this multi-disciplinary working, which the staff felt it was important to have. This was also a feature of discussions in the social worker focus group. Staff told us they hoped to secure a dedicated social work provision for the inpatient service in the future.

The community teams were multi-disciplinary and also gave examples of multi-agency working. They also had good links with the AMHPS.

Are services effective?

Good 

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

Mental Health Act (MHA)

All people who use services at the Wells Road centre were detained under the Mental Health Act (1983).

There was good adherence to the Mental Health Act (1983). We noted that rights were being read on admission and re-read at a later date as necessary. There was also pictorial help with this area. All medication cards were accompanied by the relevant T2 or T3's. Mental Health Act documentation was available and in good order, as was

evidence or tribunal hearings that had happened or were planned. Section 17 leave was recorded and risk assessed and copies of these forms were given to the people who use services.

There was evidence of the involvement of an independent mental health advocate and Care Quality Commission posters were on display.

All of the records we reviewed evidenced good adherence to the Mental Health Act.

Are services caring?

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

Summary of findings

Overall, people who used the service described staff as caring and responsive and said that they felt safe. The care plans we looked at showed people were involved in reviewing their care and progress. We also saw examples where staff made adjustments to meet people's needs. Most people said their privacy and dignity were respected, and we heard staff speaking about people respectfully.

The way in which secure services involved patients was outstanding. Each hospital had a patient forum where issues could be raised. They also had carers' forums and organised carer days each year.

The secure services held, and reported on, regular community meetings. Generally, feedback about these meetings was positive, but some people felt that they could have been more regular.

managers. It was agreed by the managers that the practice had been incorrect and this was dealt with internally according to the trust policy. According to trust policy CCTV footage is retained for 28 days to allow review if there was a need in such incidents. We were told CCTV was regularly reviewed in this way to establish what happened and whether any lessons could be learnt.

We saw an example of positive feedback from a person who had used psychology services.

People using services involvement

The care plans we looked at showed people who used the services were involved in reviewing their care and progress. People signed their care plan showing they had seen and agreed with it. People decided who could attend their care review meetings and whether they wanted relatives to attend or not. People told us they were involved in their care and were aware of what was in their care plan and could tell us about it. One person told us, "I trust them (staff)."

We were told about carers' days which were held to support carers, saw reports of these days and we saw a carers' information pack which was given to carers about the services at Rampton. There were visiting rooms for families to visit with children. This was thoroughly risk assessed beforehand and documented.

We saw advocacy was involved and people said they had advocacy involvement when they wanted to.

Written information was available in easy read format, or different languages, when needed. We saw an easy read version of the patient council meetings which were run by people using the services.

Staff were able to tell us about the mental capacity assessment process, however records did not always show assessment of mental capacity and best interest assessments. Improvements could be made in this area.

Emotional support for care and treatment

People told us they mostly received the support they needed. We saw several examples of a ward philosophy for different wards which promoted self-care and coping skills. People told us about their distress signatures which helped them cope if they became distressed.

Our findings

Rampton Hospital

Kindness, dignity and respect

Most people we spoke with said they were treated with kindness and respect, although some reported staff were disinterested and did not listen to them. When we raised specific issues with the ward managers of the ward they were aware of the concerns and were able to tell us what was being done about them. We observed most staff treated people respectfully.

When people were in seclusion, food was sometimes passed through a hatch, because of the perceived risk of opening the door. This could present an infection control risk. Staff and people who used the service said they sometimes had to shout through the hatch to speak to the people in seclusion or in their bedroom at night.

Many people told us about their distress signature, which had been developed by them with staff, to help them identify when they were becoming distressed and how to cope with their distress.

We were told about one incident by one person and were told staff had leaned on him during restraint. We asked to see the CCTV record and were able to review this with

Are services caring?

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People were encouraged to adopt healthy lifestyles and were given a choice of menus and access to the gym. We were told access to the gym could be cancelled owing to staffing shortage.

We were told about, and saw minutes of, community meetings on wards where people could meet with staff and talk about any issues and how to address them. People also told us about these meetings. The frequency of these varied across the hospital with some being weekly and others fortnightly. Most people told us they could discuss issues with staff, if needed, at any time.

Wathwood

Kindness, dignity and respect

People spoke highly of the staff and their attitude. One person told us, "X is brilliant, you can tell him anything". They also said that staff were open and fair. Another person said that they knew staff at all levels throughout the hospital, including the manager, and that they were all approachable.

Staff spoke about people with respect and demonstrated an understanding of people who use services and their needs. It was evident from our discussions with staff, across the hospital, that there was a consistent and cohesive approach to the care of people who use services. There was a strong commitment to tackling any bullying between people who use services. We noted a relaxed atmosphere on the wards and there were positive relationships between people who use services and staff.

We observed, during handover, that staff were concerned with the welfare and safety of people. Staff discussed individual people's current mental state and the interactions and relationships between and staff on the ward. During our inspection we noted that the majority of staff were on the ward spending time with people who use services. A person told us that what we saw during our inspection was how the staff always were and that they had not 'put on a show'. One member of staff told us, "I love it here. I enjoy spending time with the people and helping them". Another member of staff told us, "It's all about the patients".

People using services involvement

Throughout our inspection we heard from both people who use services and staff about service user involvement. There was a commitment from the hospital management, and all levels of staff, to listen to people and to integrate

their wishes into the running of the hospital. People told us they felt involved and listened to. During our tour of the hospital we observed that people spoke with senior managers in a relaxed and friendly manner and it was evident that positive relationships had been established.

Wathwood Hospital involved people as much as possible in the running of the hospital. There was a patients' forum, which met fortnightly, and staff told us about 50% of people who use services attended. People told us about attending the forum and it was attended by the hospital manager and the modern matron. Minutes of the forum were available across the hospital.

People told us that everybody attending the patient forum had a vote and they said that if they wanted something the hospital management listened. People had been involved in the design of the intensive care unit which was light, clean and comfortable.

The advocacy service carried out a review of all people post-seclusion so that people could discuss the causes and what staff could have done differently. This is also in place for restraint.

Emotional support for care and treatment

People who use services were supported to maintain contact with their families wherever possible. Families could visit the ward and these took place in communal areas to maintain safety. Staff discussed actions they had taken if people who use services' visitors had been disruptive. For example one person saw their family member off the ward. Staff told us that although this persons' relative had been threatening and abusive to staff it was very important to the person to see them. In this discussion staff demonstrated an understanding emotional needs and the way they balanced complex issues of security versus this emotional need.

There were suitable arrangements in place for people to see their children, providing the hospital were assured of the safety of the child and the appropriateness of contact. A dedicated family area was available for these visits and all visits were supervised by staff.

The hospital had a carer's forum which took place every three months. We spoke with carers visiting the hospital who said they thought it was very useful for new people as they were able to find out what was going on. Information was available within the hospital for carers. There was a

Are services caring?

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

comprehensive booklet available which explained the services provided by the hospital and a clear explanation of the rules and boundaries of visits. Contact numbers were provided should people need more information.

Arnold Lodge

Kindness, dignity and respect

Of the 14 comment cards we received, 10 were positive about the way people who use services felt they were treated. Typical comments included, “The team at Arnold Lodge are very supportive in all areas”, “I find that staff treat me with dignity and respect”. Some people were very unhappy about the whole hospital, and the amount of time they had been detained, whilst others felt the hospital had given them an opportunity to move forward. We followed up a complaint a person had made about their treatment and staff were able to explain the rationale for their actions and demonstrated that they had acted professionally to keep this person, and others, safe.

Staff we spoke with were consistent in describing a person-centred approach to care. They were knowledgeable about people’s needs and involved them as much as possible in planning their care. People using services on the women’s wards, had a high level of confidence in staff and described effective therapeutic relationships. We observed very good engagement between staff and people. Staff demonstrated warmth and a willingness to support people in a caring and positive way when they were distressed.

We observed staff interactions with a secluded person which were respectful, clear and inclusive and demonstrated very good practice. Medication and side effects were discussed and the person was asked how they felt staff could have managed things differently. Following consulting the service user, staff discussed the most appropriate way to manage the situation for the benefit of this person. We found that there was a lack of evidence that all four hourly reviews had been completed for this and staff confirmed there was a difficulty with out of hours doctors.

Staff working on the male personality disorders unit worked in a way that aimed to empower people who use services to tackle their difficulties and find ways of moving forward. Three people we spoke with told us, “staff are brilliant. They do care”. Staff told us that a therapeutic relationship, respect and boundaries, were essential in the running of the ward.

People who use services on Cannock were all sentenced prisoners and if, following a three month assessment they did not want to stay on the unit, staff would arrange for them to return to prison. Staff explained that sometimes a person was not ready but that they could always come back and try again. They said they would arrange for a person who used services to say goodbye in the morning meeting if that was what they wanted to do. We spoke with three people who told us it was not their first stay on the unit.

A multi-faith room was available for people to use. We were told by the hospital management that there was a wide range of provision available. This ranged from Muslim (with an arrow on the multi-faith room floor pointing to Mecca), through to Christian, Buddhist, Hindu and Pagan. They told us that Leicester was multi-cultural and that this made a wide provision possible.

People using services involvement

One person on Cannock told us that they did not want to stay on the unit and staff had arranged for them to return to prison. They had been offered support about this decision but their choice had been respected.

People who use services we spoke with knew about their care plans and had been involved in their development. The amount of engagement varied, from people who use services who did not agree with their plans at all; through to those who told us they had been very involved in writing them. People were supported to produce their own report for their CPA meetings and where appropriate were involved in chairing the meeting.

There was a strong commitment to involving people who use services in the running of the hospital. The forum met monthly and aimed to have representatives from each ward at the meeting. We saw that information was available throughout the hospital about the meetings and informed people through a poster entitled, “You’ve said, We’ve done”. For example we saw that people who use services had been unhappy about food at the hospital. In response to this menus had been changed and people involved through a catering focus group.

We were told that in the past people had participated in the interviewing of new staff but this had been stopped. We asked why this had been stopped and were told that it was because ‘the medics thought it could be a conflict of interest as they might have to make decisions people who

Are services caring?

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

used services did not like'. We were also told, 'we are a long way from the trust and it is difficult to arrange'. We were not convinced that these were clear reasons for stopping the involvement of people who use services in staff interviews. We were told there were plans to re-introduce this.

People who use services were involved in the design of new wards within the hospital. One person who showed us around their ward explained they had researched which colours were relaxing and helped people feel calm. They had been able to have rooms painted in that colour. Two other people who use services told us about the anti-bullying course they had designed and were being trained to facilitate. They were very positive about the support they had received to design the course.

The general manager of Arnold Lodge had made information available to people about the proposed introduction of Night Time Confinement at Arnold Lodge. The proposal was explicit in explaining the reasons for the proposal and the financial basis for the proposal. People who use services were told there would be a full consultation process and they would have the opportunity to give their views.

Emotional support for care and treatment

People who use services were supported to maintain contact with their families wherever possible. Families could visit the hospital and visits took place in a communal area in order to maintain safety.

There were suitable arrangements in place for people to see their children, providing the hospital were assured of the safety of the child and the appropriateness of contact. A dedicated family area was available for these visits and all visits were supervised by staff.

The hospital held carers days twice a year. There was an opportunity for families to visit wards on these occasions to see where their relative lived. Staff told us that there was a combination of activities and workshops. For example there could be a presentation about mental illness delivered by staff and people who use services to help families understand more about their relative and their treatment. Alongside this the hospital would hold a barbecue in summer or the people who use services would put on a pantomime at Christmas. The general manager told us that the number of carers attending had increased each year and at the most recent carers' day over 60 people attended.

Wells Road and Community Forensic Services Kindness, dignity and respect

One person who used the service on Thurland Ward told us they were "impressed" with the care which they had received. This person went on to tell us that staff respected his wishes and felt well supported. This person also gave positive feedback to us about their keyworker and how they had built up a positive working relationship with each other. A different person described staff as being supportive. During a ward round observed we saw staff speak with the person who used the service in a supportive and respectful manner.

Some people who used the service told us that staff would often spend much of their time in the ward office meaning people did not get as much time speaking with staff as they would have liked. One person who used the service described times when they felt "invisible" to staff because of the times staff were in the ward office. This person went on to tell us that some staff would stay in the office most of the day and would often ignore people when they knocked on the office door to talk to them.

We observed the staff of Prospect House displaying compassion towards supporting people who used the service. People who used the service, and who required injectable medicines, were given the injections in their bedrooms which helped to maintain privacy and respect.

We saw an example of how a person's leave was facilitated so they could have an alcoholic drink and how some of the restrictions, which were in place within the low, secure facilities at The Wells Road Centre, had been reviewed whilst at Prospect House. Examples of a more relaxed environment included being able to smoke and carry their own cigarette lighter.

We observed a multi-disciplinary team meeting for one person who used the service. The person using the service attended this meeting and although they were treated with respect the content of feedback given to them was carried out in what we considered to be a negative manner.

On Porchester Ward we saw that people using the service were able to control the viewing panels on their bedrooms doors so that people walking past their rooms were not able to look in. This helped to promote and maintain people's dignity and gave people a sense of privacy.

During our visit to the ward, we saw people receiving respectful support and assistance in a variety of settings,

Are services caring?

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such as within a drama group and an information technology group. In the ward round we observed, we saw staff interact with the person who used the service in a person-centred and caring way.

On Lister Ward people told us how they were given keys to their own rooms and had lockable storage in their rooms. This helped enable people keep some of their personal items both private and safe. We saw people had en-suite rooms which helped to promote a sense of independence and provided a means by which people could use toilet and washing facilities in a more private and dignified manner. We saw people who sought to speak with staff being provided with access to a private room where discussions could take place in a confidential way. Window film had been fitted on bedroom windows to prevent people in the courtyard being able to see in to people's rooms which helped ensure people's privacy and dignity.

We saw how the ward's low stimulus and seclusion rooms were separate but adjoined to each other. This meant that should the use of the low stimulation room not be successful in managing a person's level of distress and potential aggression, then the person could be moved to the adjoining seclusion room without being moved, potentially against their wishes, in front of other people. This arrangement helped to promote people's dignity and respect.

One person told us they were unhappy about some staff members who used mobile phones in the ward office. This person felt it was not fair and also frustrating because people were not allowed to freely use their mobile phones. The ward manager told us staff were not allowed to have their mobile phones on the unit and would act upon these concerns.

Whilst people told us there was a pay phone on the ward, which could be used with some privacy, people also told us that if they wished to use a mobile telephone it was only allowed at certain times and under staff supervision. We were told by several people that this supervision was often done in a group setting which meant several people would be on the phone at the same time. People felt this was not fair because it meant other people could overhear their private phone calls.

One person who used the County Community Forensic Team agreed to speak with us as part of our inspection. They described to us how the service had been treated in a

sensitive and professional way. The person who used the service told us that they were legally obligated to work with the team but if there was no legal order requiring this they would still work with the team because of the care and treatment they had received.

People using services involvement

The majority of people who used the service were able to describe to us the different ways in which they were encouraged to be involved with their care. One person explained that the doctor had explained the different possible side effects of medication to them and that the doctor had listened to their views. Another person spoke of also having been informed about the possible side effects of their proposed treatment. We also saw, during a ward round, examples of when treatments were being explained to people and that the views of people were listened to by staff. Most people told us they had seen their care plans and signed them. We saw examples of where people were given the opportunity to write advance statements.

People were aware of advocacy services available to them and were able to explain how they could access the advocacy service and described being able to trust them

One person at Prospect house was willing to speak with us. They gave us mixed feedback regarding the levels of involvement they had regarding their care. For instance, whilst they said they had 'house meetings' each day and were given help to decide where they could go for activities, they would appreciate more of a say in relation to what activities they could choose. Similarly, they felt they had little, if no, choice regarding occupational therapy groups. They were aware of the advocacy service and of their right to be able to access it.

People told us that the ward had frequent community meetings where people were able to put their views forward. We saw notices on the ward which gave people information about these meetings. People told us they had seen their care plans and were aware of what they contained. We saw examples in care records of where the views of people had been recorded and taken into account by staff.

People were aware of the advocacy service and all people we spoke with, and who had had involvement with the service, spoke favourable regarding them. One person who had used the advocacy service explained how much the

Are services caring?

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service had helped them during a mental health tribunal and how the advocacy service had helped the person get access to leave. Another person who had used the advocacy service described them as being “very good”.

During the ward round we observed on Porchester Ward, we saw people who used the service were invited and involved. We observed how one person was given information about potential side effects of their medication and how different potential activities they could become involved with was also discussed. We saw staff involve them in a discussion regarding their attendance at a course about their illness and how they could become involved with the trust’s recovery college.

We saw examples of when people were involved in the reviews of their care plans.

One person who used the County Community Forensic Team agreed to speak with us as part of our inspection. They told us they felt their views were listened to, respected and wherever possible responded to. We saw evidence from the person’s care record that they had been involved with their care planning and care planning documentation had been signed by them.

Emotional support for care and treatment

One person described how helpful their keyworker had been in supporting them.

One person we spoke with during our inspection told us Prospect House was “pretty good” and felt they were being properly cared for. The person was satisfied with the staffing levels which, for them, meant there were enough staff to talk to if it was needed. They also stated they were getting overnight leave to stay with their family.

We spoke with one staff member in particular regarding the atmosphere at Prospect House. We were told that the service had a “relaxed environment” and “homely feel”. They also felt that compared to the more intense low secure environment at The Wells Road Centre, time was much more of a luxury at Prospect House which led to an increase in the quality of care and support to those who used the service.

One person who used the service described the staff as being friendly and that they were accessing a range of services to help with their emotional well-being. Examples of such services included the Recovery College, and gym. This person also spoke to us about having completed a number of courses, such as anger management, which were contributing towards their recovery. This person went on to describe how they used the gym daily which was not only helping them to feel better physically but psychologically as well.

We saw examples of people accessing the trust’s Recovery College. This was part of the person’s care plan to help develop new skills, participate in more social and community activities and become more independent.

Lister Ward had both a low stimulation room, and seclusion room. We were shown how the rooms were able to play music, to the person’s choice, should music be a method of relaxation for that individual. This provision meant people were able to receive support which respected their individual circumstances and needs, whilst at the same time helped to keep both people using the service, and staff, safe.

Staff told us that both group, and one-to-one, therapy was provided on the ward. One told us that 90% of the staff were caring and identified some particular staff members as going out of their way to help them.

One person, who used the County Community Forensic Team, agreed to speak with us as part of our inspection. They told us the service had been very good to them during some difficult moments of their life and that they had “nearly cried due to their compassion”. This person went on to tell us how their worker, from the team, had identified them starting to become unwell but with the help of their intervention prevented them from becoming too unwell. The person explained this was very helpful as it helped to prevent them from being readmitted to hospital and helped them to maintain their independence.

Are services responsive to people's needs?

Good 

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

Summary of findings

There was an effective process in place for responding to complaints. However, the service needs to improve the way in which it feeds back to people about the outcomes of their complaints.

We saw, and were told by people who used the services, that their physical healthcare needs were met. We also observed that the different professional groups worked well together.

The medium secure services were willing to accept people on a trial basis, for example accepting people from a high secure hospital on section 17 leave, to see if it was a suitable environment. In addition, some people who had been transferred from prison were supported to return there if they wanted to.

While it was clear that care was delivered in line with individual needs, there were blanket rules in place at Arnold Lodge and the Wells Road Centre. For example, there was a limit on the number of items that people could buy from the hospital shop, but the provider had not completed individual assessments to determine if this was in everyone's best interests.

soon as possible, as the person was deemed to have capacity and so could make their choice regardless of whether it was a healthy option or not. Some people told us they could not always access sanitary wear when needed.

We saw examples of good care planning for people who required seclusion or long term segregation and also the use of strong bedding when the level of risk required it. We saw records of discussion on the potential use of mechanical or chemical restraint, and accompanying care plans when the decision was taken to use restraint. Some of the records had gaps in, for example the issue of strong bedding was not always recorded even though there was a care plan in place for its use. We saw minutes of meetings where the use of mechanical restraint was monitored and evaluated. We saw checks were made as to whether the use of mechanical restraint was care planned or used as an emergency. Most of the use was care planned.

Right care at the right time

People told us they were generally able to access appointments. One person told us an appointment had been cancelled because transport had been late to take them to the acute hospital.

We were shown plans for one person who was expected to return from an acute hospital and required end of life care.

Some people told us there were waiting lists for some groups within the hospital. Staff told us demand for some groups was high and access depended on places becoming available and the individual being ready to join or to complete the course.

Care pathway

People reported they were involved in planning their care and were able to describe what needed to happen for them to move to the next stage in the pathway. There were clear goals identified for discharge and social workers we spoke with were clear about the need for planning for section 117 aftercare arrangements.

Individual needs were catered for in relation to cultural diets and people told us they received the correct food for their beliefs. Two people told us access to their prayer service was cancelled because of staffing shortage. Some prayer meetings were held monthly. One person told us the multi-faith room they used had pictures related to another

Our findings

Rampton Hospital

Planning and delivering services

The care plan records we looked at showed people were involved in their care planning and care plans were aimed at addressing individual needs. Improvements could be made in recording mental capacity assessments and efforts made to assist people, without capacity, to make some decisions. We saw good examples of the therapeutic approach in the learning disabilities services which encouraged independence and made reasonable adjustments.

Ward philosophies we saw promoted independence and self-care. Healthy living advice was available and some wards ran healthy living groups with dietician input. One person we spoke with told us they were not able to have the meal they wanted on some occasions. This was discussed with the ward manager in regards to capacity and whether the dietician could review the situation as

Are services responsive to people's needs?

Good 

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faith on the wall, which was not conducive to their prayer. Another person told us they had been waiting some time for a hairdresser experienced in their culture to come so they could have their hair cut.

Staff on several wards told us about bed blocking, which meant people remained on a high dependency ward when they were ready to return to their parent ward, because their bed on the parent ward had been filled to allow someone to be admitted to the admission ward. We saw documentation of this in care records. For example, one person who had been in mechanical restraint, was ready for transfer back to the parent ward, but there was a delay in transfer and we were told this had a negative impact on the person's mental health and the person displayed self-injurious behaviour.

Learning from concerns and complaints

There was a trust complaints policy in place and we saw examples of how complaints were resolved. We saw minutes from a staff meeting detailing the learning from complaints.

People we spoke with knew how to make a complaint although some said they didn't for fear of reprisals.

People told us they had advocates who helped them complain if they needed to. We saw plans in place for advocacy to help with complaints.

We saw a report which contained a breakdown of all complaints received in the service and how they had been resolved, upheld or not upheld. Some people told us they were satisfied with the way their complaint had been handled and others told us they were not.

Wathwood

Planning and delivering services

People received services which were tailored to their individual needs and which were regularly assessed and reviewed by the multi-disciplinary team. Each person who used services had an assessment in respect of identified needs such as violence and aggression, sexual offending, suicide and self-harm, which informed the care pathways considered. Some people were sentenced prisoners and this was taken into account in respect of what leave was or was not available.

Each ward had an occupational therapist based there who took responsibility for delivering structured groups, supporting people who used services to engage in activities and to try new activities.

There was a wide range of treatment and therapy available to people in both groups and individually. People told us they could receive treatment for anxiety, low self-esteem, mental health awareness, substance misuse, and violent offending. In addition they said there was IT, music, the gym, swimming, catering, the farm and the farm shop.

The hospital offered people, who wished it, the opportunity to follow an apprenticeship in catering which entailed work in the hospital kitchen. All meals served in the hospital were cooked on site.

The hospital was part of the Nottinghamshire Healthcare Recovery College and offered courses to people following an adult education model. The courses on offer were, 'aiming to break down barriers' and all of the courses had at least one person with lived experience of mental health.

There was culturally specific support, for example we observed staff discussing support for one person to study the Koran. Additionally there was a gay, bisexual and transgender group which had been started following a request.

People were able to move on from the rehabilitation ward to The Lodges. We did not inspect The Lodges on this occasion but spoke with two people living there. They were very complimentary about the hospital. One person told us they now shared a flat within The Lodges with another person and was moving towards independence.

Right care at the right time

One person raised concerns with us that they had been secluded for two weeks and had not been offered any time with their named nurse. We carried out a thorough review of this person's records and found that there had been appropriate use of seclusion on three occasions. These involved two actual, and one attempted assault, on nursing staff which had resulted in three separate incidents of seclusion. Due to the person's recorded history of extreme violence the use of seclusion in these circumstances was proportionate. Records also showed regular contact with their named nurse.

Are services responsive to people's needs?

Good 

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

People we spoke with told us they could always speak with staff and felt that staff would help them as much as possible.

Care pathway

People had the same consultant from their pre-assessment to discharge. If a person did not get on with their consultant, and they both agreed it was not working, they would transfer to another consultant.

People told us it was made explicit how they could progress in order to move into the rehabilitation ward and begin to plan to move to low secure and then the community.

The care pathway audit showed 97% of actions completed and 90% completed across the hospital.

Learning from concerns and complaints

Wathwood Hospital demonstrated a high commitment to involving people and carers in improving services. People we spoke with told us that they were listened to and were able to raise issues at morning meetings and in the patients' forum, which was attended by the hospital manager and the modern matron. The hospital management had a commitment to dealing with issues raised by the patients' forum. Following meetings, the forum minutes were published and available throughout the hospital. One example was that had complained about the food and this had resulted in a change to menus.

People had access to an advocate and there was information about the service available on all wards. People confirmed they knew about the advocacy service. The hospital involved advocates in reviews of restraint and seclusion in order to obtain people's views on how situations could have been managed differently by the staff.

We looked at records of one complaint that had been made and saw that this had been investigated thoroughly.

Staff at all levels told us they were confident in raising concerns and they felt listened to. Staff meetings on the ward were attended by the modern matron.

The provider's log of complaints showed that of 10 complaints made in the previous year, two had been upheld and two were still outstanding.

Arnold Lodge

Planning and delivering services

All of the people using services had complex needs and Arnold Lodge was able to offer a range of care for people who needed to be in a medium secure environment. There were facilities for men with mental illness consisting of assessment, continuing care and rehabilitation wards; two wards for men with personality disorders; and two women's wards delivering standard and enhanced medium secure care.

People received services, tailored to their individual needs, and these were regularly assessed and reviewed by the multi-disciplinary team. Each person had an assessment in respect of identified needs such as violence and aggression, sexual offending, suicide and self-harm which informed the care pathways considered. Some people, who were sentenced prisoners, had this taken into account in respect of what leave was or was not available.

Each ward had access to occupational therapy who delivered structured groups, supporting people to engage in activities and to try new ones.

Education was available to people who used services, ranging from basic literacy and English as a second language to people undertaking Open University qualifications. One person we spoke with said they had completed a degree with the Open University.

The hospital was part of the Nottinghamshire Healthcare Recovery College and offered following an adult education model. The courses on offer included a spiritual and pastoral course on how to become a buddy. The hospital offered a buddy system for new people where a current person on the ward would undertake to support a new person during their induction onto the ward. In addition to this people were involved in staff induction, for example, teaching new staff about self-harm.

Right care at the right time

People had access to physical healthcare from a local GP who came into the hospital weekly. There was also a senior nurse health care manager with an acute hospital care background. Staff included a non-medical prescriber who led on epilepsy and diabetes and associate practitioners who provided health clinics. The hospital had a podiatry service and a dental suite onsite. We were told there was a good relationship with the local hospital who were always happy to provide advice and support.

Are services responsive to people's needs?

Good 

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

Care pathway

The hospital management told us they were 'willing to take a risk' with some people's referrals and give people the opportunity to try Arnold Lodge. Men on the personality disorder unit had a trial period and we were told most chose to return to prison within three months. Of men who stayed, those staying for more than nine months experienced a positive change. People were also admitted from Rampton high secure hospital and were able to initially come to Arnold Lodge on Section 17 leave.

Arnold Lodge worked with other providers and services to in supporting service users to develop skills and to move on where possible. People were able to take part in the work skills project, which included running the on-site shop, working in the hairdressing salon, the gym and the library. People could also work for the bike cleaning service. People were also able to work up to having leave, working in a local garage or the Mind shop. Staff told us this helped to give people hope that they could leave hospital and live in the community.

We spoke with one person who told us they were moving to a low secure unit and planned to train as a peer support worker.

Whilst it was evident that almost all care was planned and delivered in line with people's individual needs there were blanket rules in respect of the shop which was open twice a week. This was the only access to some items for people who did not have leave. We asked the associate forensic director what happened if people wanted or needed anything on days the shop was closed and he replied, "They wait".

In addition there was a restriction on how much people could buy. These restrictions were applied to all people buying anything from the shop; however did not apply to what people on Section 17 leave could buy. We were told the restrictions on the amount of crisps, chocolate, soup, Ryvita etc. was because of the tendency of psychiatric inpatients to be obese. Psychology staff explained this was a form of self-harm which was why, with input from the patients' forum, the restrictions had been introduced.

There had been no individual capacity assessments carried out for any person to determine if this restriction was in their best interests – if they did not have capacity. Additionally, over eating and weight gain was not an issue

for all people. We were concerned that this blanket rule had the biggest impact on the most restricted people with no leave and who were confined to the hospital and its grounds.

Learning from concerns and complaints

Arnold Lodge demonstrated a high commitment to involving people and carers in improving services. People we spoke with told us that they were listened to and were able to raise issues at morning meetings and in the patients' forum.

During our tour of the hospital one person approached the general manager, who they evidently knew well, and asked to make a complaint. There was an appropriate response and this person was directed to a member of staff who could support them.

Wells Road and Community Forensic Services Planning and delivering services

We saw evidence of adjustments being made to people who used the service when their first language was not English; for instance, we saw the service making use of an interpreting service to ensure communication between staff and the person was facilitated. Staff told us there were no limitations placed upon them in terms of when interpreters could be used and this included care plan review, ward reviews and key worker sessions.

We saw examples of the service engaging with other services about the plan for a person's discharge and transition through the care pathway. We saw the ward had engaged with other services before people were admitted so that they could help plan for a person's care.

We saw evidence where good links had been established with others regarding a person's care plan and how these should be delivered. Ward staff worked with people in a way which helped to plan their ongoing care. For example, the ward had a 'moving on group' which was where staff would engage with people and delivered education and support on a range of issues which people felt were needed for their health and wellbeing. Such topics discussed in the group included issues of mental health relapse, psychiatric medications and possible transition to Prospect House.

The PD network offered a range of interventions, including group work. They also tried to increase people's motivation to engage by following up assessments with telephone calls.

Are services responsive to people's needs?

Good 

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

Right care at the right time

We saw how Prospect House had been engaging with other teams and services to help provide coordinated plans of care. We saw an example of how the unit had proactively followed up on a referral to an external service, for a person, to help minimise the risk of their care plan being disrupted. People were encouraged by staff to engage with local services as part of their recovery plans. This also helped to reduce barriers to social inclusion which, ordinarily, people with mental health difficulties can often face.

The PD Network also offered a "step through" programme based on therapeutic principles and to access this programme people did necessarily require any formal diagnosis. This service also offered consultancy and support to CAMHS (16-18 year olds) with emerging Personality Disorders.

Care pathway

The Wells Road Centre unit had an understanding of the need to meet the religious and spiritual needs of people who used the service. Staff encouraged people to talk to them about their religious needs and they would endeavour, where possible, to make some space available on the wards for religious observation. For security reasons, there was an approved list of religious leaders who were allowed to come to the ward and meet with people. The unit had a cultural awareness file to help provide assistance to staff to meet the cultural and spiritual needs of people using the service. The unit also held multi-faith services and we saw how this was being advertised and promoted.

Adaptations to the wards were possible for those people who were not allowed to leave so that they could access a 'pop up classroom'. Speech and language therapy services were playing a role in people's care and had played a key role in helping to adapt written materials in to a format which could be understood by people with a learning disability. We saw how the service had produced simplified versions of information so people who used the service were better informed and involved with their care, and also saw how pictorial summaries of care plan reviews had been produced.

The community teams had a clear referral pathway and the PD Network offered different treatment options. The

community forensic teams also accepted people from a number of routes including general adult's mental health, secure hospitals, prisons (offender health), and probation and out of area placements.

Learning from concerns and complaints

The public entrance/reception area to the Wells Road Centre had a comments box attached to the wall. However, there were no comment cards freely available or means to write on the cards. We asked staff about this and were told the comment cards were kept by the reception staff. This meant that any person wanting to make a comment would have to ask staff for a comment card and something to write with. It was our view that this created a barrier as many people may be put off by having to approach staff to ask. Nor was it clear who you had to ask for a comment card to complete. It also meant that should a person wish to provide anonymous feedback it was much easier for staff to be able to identify the person, particularly if only one comment card was completed.

In the unit's coffee bar there was a comments book for people who used the service. However, there was no evidence of it having been read and actioned. For example, whilst we saw some comments were present from February 2014 there was nothing to indicate to people that management had read the book, or what actions they intended to take from the feedback received.

One person agreed to speak with us as part of our inspection. They told us they did not know how to make a complaint. However, we also saw some feedback forms which relatives of a person who used the service had completed. These forms contained positive feedback about the service provided by Prospect House.

We received mixed messages regarding how people could complain. One staff member told us the procedure was for the person to speak with the ward manager. Other staff told us there were several ways in which complaints could be raised such as through the advocacy service, speaking with the ward manager or raising it at the ward's community meeting. We also saw that there was no information clearly visible on the ward describing how to make a complaint.

We attended a ward round during which a person expressed some upset regarding how a member of staff had spoken to them. Staff gave assurances to the person that this would be acted on.

Are services responsive to people's needs?

Good 

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

Staff we spoke with on the ward could explain to us different ways by which people could raise any concerns and provide feedback. People had several different methods by which they could provide feedback, such as by

contacting the advocacy service or speaking with managers. Staff told us people who use services were also given written information, at the point of admission, regarding how to raise concerns.

Are services well-led?

Good 

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

Summary of findings

There were processes in place for staff supervision and appraisals, which helped deliver safe and effective care. Staff confirmed that they had an annual appraisal and received regular clinical supervision. However, supervision from managers, and the recording of the supervision given, could be improved. Staff said that they felt well supported by their manager, and that they could raise any concerns and were confident that these would be addressed. The way in which the organisation was led focused on providing high-quality, person-centred care, and promoted an open and fair culture.

The people using services, and staff, had regular contact with senior members of staff, for example modern matrons. We saw in our focus groups with senior staff in the secure services that staff were dedicated to, and passionate about, their roles.

Our findings

Rampton Hospital

Vision and strategy

The trust quality strategy highlighted a number of ways in which the trust provided staff leadership for quality. We saw a booklet outlining the quality priorities and the values were visible throughout the hospital.

Responsible governance

Staff we spoke with were clear about their responsibilities in relation to raising concerns about quality of care. Many staff raised concerns with us about the staffing levels not being sufficient to meet demand and all were aware of the cost improvement plans in place which had impacted on staffing levels. For example night-time confinement was implemented in order to reduce staffing levels and save money.

There was a trust audit programme in place which included audits of forensic services and actions arising.

Leadership and culture

All staff told us they received regular clinical supervision both individually and in peer (multi-disciplinary) groups. One member of staff told us they were clinically supervising 16 staff as well as their nursing duties. The CQC would

question the effectiveness of one member supervising 16 staff. There was a strong emphasis on promoting staff well-being within the teams and we saw staff were respectful and supportive of each other.

We were told by one ward manager that they had completed the trust leadership programme.

We observed staff talking about people in relation to their care and staff were respectful and caring and wanted to achieve high quality of care for the people using services.

Engagement

People who used the service said they could raise any concerns however some said they felt there might be repercussions if they did. We saw boxes on many wards into which people could put their comments. Staff told us they tried to resolve any issues locally in the first instance rather than taking it through the formal complaints process.

There were regular community meetings where people could raise concerns and regular one to one sessions with staff to discuss any issues as well as their care. Some people told us one to one sessions were sometimes cancelled if staffing levels were reduced.

Staff we spoke with said they could raise any concerns with their manager and said they felt the concerns would be addressed. They all said their manager was approachable and kept them informed. They told us they were aware of the trust's whistleblowing policy and their responsibilities in relation to reporting concerns. Some staff were not aware they could also contact the Care Quality Commission directly with any concerns.

The advocacy service told us they were able to help people and had good access to wards when needed.

Performance improvement

The trust quality strategy highlighted a number of ways in which the trust provided staff leadership for quality. We saw how the hospital learnt from incidents and complaints.

Staff told us objectives for improvement were identified in their annual appraisal. All staff were aware of the cost improvement plans.

Wathwood

Vision and strategy

People and staff at the hospital were aware of, understood and felt involved in the trust's vision and strategy. The trust

Are services well-led?

Good 

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prioritised involvement of people using services and throughout our conversations with staff it was evident that they understood and supported this strategy. People who use services told us that they were involved in interviews for new staff members.

The trust had a strong recovery focus and this was embedded in practice at the hospital. There was access to the Recovery College and a range of work opportunities for people to engage with. Staff we spoke with were enthusiastic and positive about the direction the trust was moving in. Both staff and service users spoke with pride about the hospital, its current achievement and future plans.

Responsible governance

We were told by the hospital management that responsibility for the majority of decisions was devolved by the board. Managers discussed how they had been able to make decisions around financial management which had enabled them to build a swimming pool. They were aware of the cost improvement plans and had addressed this by the opening of The Lodges, which had improved their financial situation.

Performance was measured at ward level with a set of benchmarks which included percentages of completion for supervision, appraisals, care planning and risk assessing. This was a live electronic system and enabled ward managers to identify where action was needed.

Leadership and culture

People and staff were very positive about the leadership within the hospital. People knew the general manager of the hospital and during our tour of the hospital we observed that people knew who he was. We observed mutually respectful interactions between senior staff and people and people knew who the chief executive of the trust was and had met and talked with him.

It was evident that a culture of service user involvement was embedded within the hospital. In speaking with both people and staff the patients' forum was mentioned by all. Staff told us there was an open and mutually supportive culture within the hospital. Staff we spoke with told us they were proud to work at the hospital and were very positive about the multi-disciplinary working and the support they received.

Each ward had wireless IT access which enabled staff to spend time outside the office using a laptop. The modern

matron told us staff were encouraged to be out on the ward as much as possible and we observed that staff did spend the majority of their time out of the office. On one ward we talked with the manager about the running of the ward and this took place in a communal area with a person who uses services present. We felt this was a good example of openness in how the hospital ran.

Staff told us they received mandatory training and we saw records were kept of this.

Engagement

Regular surveys were undertaken amongst both staff and people. Additionally there was a public website where people could express their views and receive a response from the trust. The majority of the most recent posts involved proposed night time confinement which people who use services were unhappy about. Responses from the trust confirmed there were no plans to roll this out at Wathwood. Other posts on the patient opinion site expressed positive views of their experiences at the hospital.

People who used services confirmed they could raise any issues at morning meetings or at the patients' forum. They confirmed they felt listened to by the hospital management. People told us there was access to advocacy and we saw information displayed on wards about this service.

Staff were able to raise concerns and to contribute at all levels to person's well-being. Staff confirmed that they would be listened to.

Team meetings were held regularly on the ward and these meetings were attended by the modern matron.

Performance improvement

The trust quality strategy highlighted a number of ways in which the trust provided staff leadership for quality. The wards had clear philosophies, and all staff had yearly appraisals as part of their performance development. Regular and structured supervision sessions were taking place regularly.

Arnold Lodge

Vision and strategy

People and staff at the hospital were aware of, understood and felt involved in the trust's vision and strategy. The trust prioritised involvement of people using services and throughout our conversations with staff it was evident that

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they understood and supported this strategy. People we spoke with told us that they were involved in the patients' forum and contributed to any improvements or changes to the hospital environment.

The trust had a strong recovery focus and this was embedded in practice at the hospital. There was access to the Recovery College and a range of work opportunities for people to engage with. Staff we spoke with were enthusiastic and positive about the direction the trust was moving in. Both staff and people who use services (on some wards) spoke with pride about the hospital, its current achievement and future plans.

Responsible governance

We were told by hospital management that responsibility for the majority of decisions was devolved by the board and this worked well.

We saw that there was a system of management meetings, which discussed and monitored areas such as safeguarding, security and seclusion reports, staff assaults report and the follow up of various action plans.

Leadership and culture

People and staff were very positive about the leadership within the hospital.

It was evident that a culture of service user involvement was embedded within the hospital. In speaking with both people and staff the patients' forum was mentioned by all.

Staff told us there was an open and mutually supportive culture within the hospital. Staff we spoke with told us they were proud to work at the hospital and were very positive about the multi-disciplinary working and the support they received. We were told by staff that if they had difficulties either at work or at home the hospital would provide help and support.

Staff we spoke with described cohesive teams which worked well together. One example given was of staff knowing which colleagues were best at tasks following an incident. For example some staff were better at de-escalation whilst others were good at providing physical care. They explained that working to people's strengths had good outcomes.

Staff told us they received mandatory training and that there was good access to supervision.

Engagement

Regular surveys were undertaken amongst both staff and people who use services. Additionally there was a public website where people could express their views and receive a response from the trust. We looked at the website and saw that only one person had posted on this – a positive comment about the black and ethnic minority social club.

People confirmed they could raise any issues at morning meetings or at the people who use services' forum. They confirmed they felt listened to by the hospital management. People told us there was access to advocacy and we saw information displayed on wards about this service.

Staff were able to raise concerns and to contribute at all levels to people's well-being. Staff confirmed that they would be listened to.

Performance improvement

The wards had clear philosophies, which all staff were working towards as part of their performance development. Regular and structured supervision sessions were being undertaken, which included individual feedback.

Wells Road and Community Forensic Services Vision and strategy

Staff we spoke with about governance as part of our focus groups gave favourable feedback regarding the trust's vision. The trust was described by some staff as being "forward thinking" and supportive of innovative thinking. Staff we spoke with felt confident in the overall vision of the trust. Staff felt there was good communication from the board level and felt that the chief executive was accessible to both staff and people.

Responsible governance

Staff we spoke with at our focus groups told us they were aware of where corporate policy and processes were kept and how these contained guidance and direction on practice delivery. Some of the more senior staff within the unit felt they were able to help shape strategic direction. Some staff spoke about how robust the line management structures were and how some of the trust's policies were very clear and helpful in making sure people who used the service were safe and ensuring compliance with the law.

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Leadership and culture

We received consistently positive feedback from staff during our focus groups regarding the leadership of both the unit and trust as a whole. Examples of comments we received included, “it’s a really good trust” and “I feel very impressed by the care and support given to staff by the trust”. Staff also spoke positively about ward leadership within The Wells Road Centre. Some staff in the focus groups spoke of how much better led, and supportive, the trust was compared to previous places they had worked.

Engagement

The overwhelming majority of staff we spoke with at our focus groups felt the trust engaged well with a range of stakeholders, including staff and people. Staff we spoke with appreciated working for the trust and felt they were well supported by its leadership. The majority of staff we spoke with felt the trust valued them and were keen to provide a climate consisting of support and professional recognition. Staff gave us examples of how the trust had been supportive of them at times of ill-health, and how the trust had been flexible for those with children and other carer responsibilities.

An advocacy service was in place within the trust and its service appeared to be well embedded, particularly with

people who used the service at ward level. People gave positive feedback about the advocacy service and gave us examples of how the care provided by the trust had changed as a result of advocacy feedback.

We saw how the service engaged a range of people in the departmental management meeting which included patient advocacy and staff side representation. We were told how people were given the opportunity to be involved in staff recruitment.

Performance improvement

The overwhelming majority of staff we spoke with at our focus groups were positive about how the trust supported them to develop professionally. Staff told about how they received supervision and how this supervision could be delivered in different ways. For example, there was one-to-one supervision with managers but also peer support provisions for some staff. Some staff raised some hesitation, however, and pointed out that this level of support and supervision could be much less if, for instance, a worker was working on their own in a community team. Staff told us that they received performance appraisals. Medical staff in particular spoke of receiving much encouragement for establishing and developing academic links and pursuing research.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Reg 9(1)(b)(iii) The provider did not always follow the appropriate guidance in respect of good practice for seclusion reviews at Arnold Lodge.