Arbury Court

Quality Report

Townfield Lane
Winwick
Warrington
Cheshire
WA2 8TR
Tel: 01925 400 600
Website: www.elysiumhealthcare.co.uk

Date of inspection visit: 23-25 July 2019
Date of publication: 28/11/2019

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, mostly managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions, and encouraged and supported them to keep in touch with each other.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Good 	Good

Summary of findings

Contents

Summary of this inspection

Page

Background to Arbury Court 6

Our inspection team 6

Why we carried out this inspection 6

How we carried out this inspection 7

What people who use the service say 7

The five questions we ask about services and what we found 8

Detailed findings from this inspection

Mental Health Act responsibilities 12

Mental Capacity Act and Deprivation of Liberty Safeguards 12

Overview of ratings 12

Outstanding practice 28

Areas for improvement 28

Good

Arbury Court

Services we looked at:
Forensic inpatient or secure wards; Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Background to Arbury Court

Arbury Court has 82 beds for women aged over 18 diagnosed with a mental illness or personality disorder. Some of the women may have a learning disability in addition to a mental illness. All patients are detained under the Mental Health Act. Five of the wards provide forensic or secure services, and one ward is a psychiatric intensive care unit.

There are 44 low secure beds across three wards:

- Appleton ward - 15 beds
- Cinnamon ward - 14 beds
- Heathfield ward - 15 beds.

There are 27 medium secure beds across two wards:

- Delamere ward -12 beds
- Oakmere ward - 15 beds.

There are 11 psychiatric intensive care beds on Primrose ward. Primrose ward has its own consultant psychiatrist, ward manager and nursing team, but is integrated within

the rest of the service.

Patients are admitted from across the United Kingdom. Secure beds in England are commissioned by NHS England, and different authorities in Wales and Northern Ireland. Beds in the psychiatric intensive care unit are commissioned by individual NHS trusts and authorities.

Arbury Court is registered to provide the regulated activities: treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures. Arbury Court, as part of Elysium Healthcare Limited, was registered with CQC on 21 October 2016, and has a registered manager.

Arbury Court was last inspected by the Care Quality Commission in August 2017. Arbury Court was rated as requires improvement in the safe domain; good in the effective, caring and responsive domains; and outstanding in the well led domain. The overall rating was good.

At the last inspection we issued a requirement notice for a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were occasions when medicines were out of stock which led to doses being missed, and monitoring of patients after rapid tranquilisation was not always carried out or recorded in patients' records. At this inspection we found that these requirements had been met.

Our inspection team

The team that inspected the service comprised an inspection manager, three CQC inspectors, a Mental Health Act reviewer, a specialist pharmacy inspector, two nurses and an occupational therapist.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information about the service.

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 28 patients
- spoke with two carers or relatives of patients
- collected feedback from 17 patients and two staff, from comment cards across all six wards
- spoke with the registered manager, managers or acting managers for each of the wards, and other managers within the service
- spoke with 44 other staff including doctors, nurses and healthcare workers, occupational therapists, psychologists, social workers and non-clinical staff
- spoke with an independent advocate
- reviewed 39 care records of patients
- reviewed 44 prescription charts
- reviewed the management of medicines and spoke with an external pharmacist
- observed six meetings which included multidisciplinary team meetings, a community meeting, a daily handover, and staffing and governance meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

We have reported on forensic inpatient secure wards and the psychiatric intensive care unit together within this report due to the relatively low number of beds within the psychiatric intensive care unit.

What people who use the service say

We spoke with 28 patients, two carers or family members of patients, and received 17 comment cards from patients.

The feedback we received from patients – directly and through comment cards – was mostly positive. Patients found most staff to be responsive, helpful, friendly, kind and caring.

Most of the comments cards were positive about the care patients received. This included positive comments about the service generally and that staff were kind, caring and helpful. There were individual examples of specific therapies and interventions that patients had found helpful. Where patients made negative comments, there was no overall theme but comments included that patients felt staff were too busy, and that there should be more activities.

The patient satisfaction survey showed that there had been an increase in respondents from ten in 2017/18 to 22 in 2018/19, and there were improvements in most areas. An action plan was developed in response and included information provided on admission, knowing who their buddy and care co-ordinator were, quality of food, information about side effects of medicines and having copies of care plans and care programme approach meetings.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of this service improved. We rated it as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received training to keep patients safe from avoidable harm. The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. The use of restraint and seclusion was routinely reviewed to ensure that this was only used after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The management of medicines was not always carried out correctly.
- Investigations into incidents were detailed, but did not always attempt to identify the 'root cause' of the incident.

Summary of this inspection

Are services effective?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Although positive behaviour support plans were good for patients who were willing and able to engage with them, this was not always the case for patients who could or would not do so.

Summary of this inspection

- The monitoring of the Mental Health Act did not always identify or respond to errors or changes to the patient's Mental Health Act status in a timely way.

Are services caring?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. Patients and their families were actively encouraged and supported to keep in touch with each other.

Are services responsive?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of adequate quality and patients had access to hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

Our rating of this service went down. We rated it as good because:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

However:

- There had been gaps in the implementation of the Mental Health Act, and the management of medicines, that had not been addressed through the governance system.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Mental Health Act training was mandatory for nurses, doctors and social workers. Over 95% of these staff had completed this training.

There was a Mental Health Act administration team on site, who provided advice and support for staff. There had been some errors in the administration of the Act, which had been identified by the provider and addressed. This included some consent to treatment forms which had not been filled in correctly, but these were rectified during our inspection.

All patients at Arbury Court were detained under the Mental Health Act. They had access to an advocacy service. Patients had their rights under the Mental Health Act explained to them, and this was monitored through the governance dashboard. The monitoring of the Mental Health Act did not always identify or respond to errors or changes to the patient's Mental Health Act status in a timely way.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Patients in the service were usually detained under the Mental Health Act, and there had been no patients subject to Deprivation of Liberty Safeguards in the twelve months up to this inspection.

Each patient's capacity was discussed in the multidisciplinary team meetings. Patients were assessed for their capacity to make specific decisions, and supported to make these decisions where possible.

Patients had access to an independent mental capacity advocate when required. When patients were deemed not to have capacity, decisions were in made in a patient's best interest. Examples of this included patients' finances, treatment for physical health conditions, and future accommodation. Patient's families were involved in best interest discussions when appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory for nurses, doctors and social workers. Over 88% of these staff had completed this training. Staff understood the principles of capacity.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Good

Safe and clean environment

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Environmental risk assessments, including ligature audits, were routinely carried out. The most recent ligature audits had been carried out in March 2019. When concerns were identified this had been addressed, or action had been taken to mitigate the risks. This included the use of enhanced observation of patients, regular monitoring of areas of the ward, such as communal areas, and locking of areas that contained risk items, such as kitchens. This was risk assessed on each ward, and for individual patients.

All staff had access to emergency alarms, which alerted other staff to attend and assist. There were nurse call points in patients' bedrooms. Ligature cutters were stored in areas that were accessible to staff.

The service only admitted women, so there was no mixed-sex accommodation. All patients had their own bedroom with an ensuite shower and toilet. All patient accessible areas had anti-barricade doors. Bedrooms and bathrooms had anti-ligature fittings.

A security nurse was allocated for each shift on each ward. Their role included checking the environment for risks to patients, and identifying and reporting any maintenance or repairs. The service was clean and maintained. Damaged items were reported and repaired or replaced.

Most staff had completed infection control training, and there was access to handwashing facilities and personal protective equipment across the site.

There were seven seclusion rooms across the hospital, which included a seclusion room on the psychiatric intensive care unit (Primrose ward). The rooms met the criteria of the Mental Health Act Code of Practice. They had clear observation, two-way communication, controllable light and heat, access to a toilet and shower, and a visible clock. The fabric of the rooms was reviewed and replaced when it was found to be unsuitable for individual patients. Some patients were in long term seclusion or long term segregation. Some of the bedrooms had been adapted to reduce the risks to patients, whilst allowing them to keep some of their belongings.

The clinic rooms on the wards were clean and maintained. Staff had access to emergency medical equipment and medicines. Staff carried out routine checks of emergency equipment. Physical examinations were usually carried out in a separate clinic room which was overseen by the nurse practitioner.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

At the time of the inspection the inpatient wards had 56.5 registered nurse posts, of which 13.4 were vacant. Eight of the vacant posts had been recruited to but the staff had yet to start. There were 113.8 health care worker posts. There were no vacancies, but 35 staff had been offered posts and were yet to start. The service aimed to over-recruit to health care worker posts, to provide cover within the

service. In addition to the baseline staffing levels on each ward, extra staff were needed for enhanced observations, which included leave, seclusion, and long term segregation.

The service used the safer staffing model used in the NHS to monitor its staffing levels. A resource administrator monitored and reviewed staffing levels across the whole unit each day. Staffing levels were reviewed in the daily morning handover meeting, and staff were moved between wards if necessary. A specific staffing meeting took place once or twice a week, depending on need, where the resource administrator and ward managers met to review staffing for the following week. This included checking the proposed allocation was correct, and noting any potential issues such as levels of observation, sickness or expected events. Requests for cover were identified, and staff were moved between wards if necessary taking account of issues such as the mix of permanent and bank/agency staff, male and female staff, or any staff who were not trained in the therapeutic management of violence and aggression.

Bank and agency staff were regularly used. From 1 February 2019 to 3 April 2019, 1795 shifts were filled by bank staff and 2111 shifts by agency staff. Bank staff received an induction, and the same training as permanent staff, including the therapeutic management of violence and aggression once they had completed a set number of shifts. Agency staff received an induction, and had expectations as to the training and skills they had before they could work at the service.

From 1 February 2019 to 3 April 2019 261 shifts were unfilled by bank or agency staff. Managers told us that these figures did not take account of staff who worked nine-to-five or twilight shifts. Staff told us that the wards were busy and there were staffing pressures, but this varied between wards and they kept patients safe. They told us that cancelling of leave or activities because of staffing levels did happen, but was not that common. Staff told us that leave may sometimes be delayed, rather than cancelled. This was broadly consistent with what patients told us.

The sickness rates for nursing staff and healthcare workers, for the year up to 30 April 2019 ranged from 3.1% on Heathfield ward to 7.5% on Cinnamon ward.

The service had an ongoing recruitment programme, which included open days and engaging with universities. All new staff had recruitment checks completed before they started working in the service. Managers told us the recruitment process had become quicker and easier, since the recruitment processes were now carried out from Arbury Court rather than centrally. Managers told us there were a number of initiatives they were working on to improve staff support and the retention of staff. There was a staff support lead and staff counsellor, who were available to staff to help them address personal and work-related stressors.

The service had five consultant psychiatrists. This included the medical director, and a locum doctor providing cover. Each consultant was the responsible clinician for patients on one or two specific wards. Physical healthcare was provided by a nurse practitioner at the service, and a GP who visited each week. Out of hours medical cover was provided through Elysium's regional oncall rota. This was a consultant rota, and this included some of the doctors from Arbury Court. Medical staff told us that they provided phone and onsite support when oncall, which included seclusion reviews for Elysium hospitals within the region.

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service had identified mandatory training for each of the roles within its service. Staff were able to access e-learning through Elysium's training system, which also recorded what training staff had completed, and sent reminders when training needed to be completed again. Face to face training was carried out when necessary, such as the therapeutic management of violence and aggression, and breakaway training. Staff were up to date with their mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement positive behaviour support plans with some patients, and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Good

Forensic inpatient or secure wards

We reviewed 39 care records of patients. Patients were assessed in relation to their mental and physical health, and all patients had an up to date risk assessment. Risk assessments were completed on or prior to admission, and reviewed in multidisciplinary team meetings. Changes in risk were discussed in the daily unit-wide meeting. Research-based risk assessment tools were used, which included the short-term assessment of risk and treatability, and the historical clinical risk management-20 tools.

Patients had plans of care developed from these assessments, which included positive behaviour support plans. We found that when patients had contributed towards the plans and showed insight into their own mental health difficulties, their positive behaviour support plans provided a good range of proactive and reactive strategies that staff could use to reduce risk, alleviate the patient's distress and work towards recovery. Although some of these plans lacked detail, for example saying 'offer distraction' without listing what specific activities were known to effectively distract the patient; staff were able to tell us most of the early warning signs and interventions that were listed in the plans. Staff told us that in addition to the plans being recorded in the electronic care record, the content of the plans was discussed during handovers, multi-disciplinary team meetings and in reflective practice sessions. However, where patients lacked capacity and/or declined to be involved in the positive behaviour support plans, there had been no functional analysis or other methods used, to determine the meaning behind the patient's risk behaviours. This limited the plans as they did not identify potential triggers for behaviour, or reliable ways of responding to them in order to de-escalate situations.

All patients at Arbury Court were detained under the Mental Health Act. The level of restriction varied between wards, and was individually risk assessed. Blanket restrictions were in place on some of the wards, which included restrictions on specific items and limited access to bed areas or toilets. This was discussed in community meetings, at the patients' council, and through the hospitals governance meetings. Smart phones were not allowed on any of the wards, but non-camera phones were allowed on some wards after risk assessment. The property patients had in their bedrooms was individually risk assessed.

The hospital had a no-smoking policy. Patients had access to nicotine replacement therapy and support.

In the six months up to 30 April 2019 there were 98 episodes of seclusion. This ranged from four on Heathfield and Cinnamon wards, to 32 on Appleton ward. In the six months up to 30 April 2019 there were 45 episodes of long term segregation. This ranged from two on Heathfield ward, to 13 on Appleton ward. Patients in seclusion were reviewed in accordance with the Mental Health Act Code of Practice, and records were completed correctly. This included routine reviews by the multidisciplinary team, consultant psychiatrist, and external staff. Patients in long term seclusion or segregation had individual care plans that encouraged activities and, for example, maintained contact with their families.

In the six months up to 30 April 2019 there were 917 episodes of restraint. This ranged from 19 on Cinnamon ward (involving six patients) to 274 on Delamere ward (involving 14 patients). There were 73 prone restraints, 32 of which involved rapid tranquilisation. There were no prone restraints on three of the wards (Cinnamon, Heathfield and Oakmere). All restraints were recorded in the incident management system, and were discussed in the daily managers' meeting. This included incidents of prone restraint, and why they had occurred. Managers told us that Elysium had updated its training programme to emphasise that patients should be restrained on the floor as a last resort, and supine (face up) restraint was the first option if this was necessary. Staff were also trained in how to turn over a patient in the event that they were in a face down position.

Most staff had completed the relevant mandatory training. This included the prevention and management of violence and aggression (92.5% of 174 staff), conflict resolution (over 95.8% of 262 staff), breakaway (95.8% of 262 staff), and security training (85.9% of 262 staff).

The service monitored the use of all restrictive interventions, including restraint, seclusion, long term segregation and enhanced observations. Detailed information was recorded in the patient's records, and in the incident report system. This fed into a 'dashboard' where the information could be analysed and action taken. The information could be reviewed for individual patients, or for specific wards or criteria, such as time of day. The information was reviewed in the daily senior management team meeting where all incidents including restrictive

interventions and the use of rapid tranquilisation was reviewed. In the monthly governance meeting the information was reviewed 'live' on screen, and reports can be generated to get more detail or to compare data.

Arbury Court had completed the reducing restrictive practice commissioning for quality and innovation target, set by its commissioners. This included staff training on reducing restrictive practice at induction; and reviewing restrictive interventions through patients' community meetings, patients' council, and the service's governance.

At the last inspection in 2017 we found that the monitoring of patients after rapid tranquilisation was not always carried out or recorded in patients' records. At this inspection we found that staff recorded patient's physical observations after rapid tranquillisation. The rapid tranquilisation policy was reviewed, and flow charts were displayed for staff. Staff told us that the medicines competency assessment included the use of rapid tranquilisation and physical health care monitoring. Staff used a standardised tool to monitor physical healthcare observations, and this was used to monitor patients after rapid tranquilisation. The use of rapid tranquilisation was reviewed in the daily management meeting, and at hospital governance.

Staff were able to response to a medical emergency. Most staff had completed basic life support training (91.1% of 258 staff). Immediate life support training was identified as mandatory for registered nurses and psychiatrists, and 93.9% of 66 staff had completed this.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The social work team led on safeguarding within the service, and were the main liaison with the local authority's safeguarding team. Staff were aware of potential safeguarding concerns and knew how to report them. Safeguarding concerns were discussed at the morning management meeting, that a social worker attended. Records were maintained and reviewed of 'low level' incidents, usually between patients, that did not meet the criteria for further investigation by the local safeguarding authority.

Ninety-three percent of staff had completed safeguarding adults and children training, and 87.4% of staff had completed prevent training.

There were visiting rooms for adults and children, which were within the hospital buildings. The social work team co-ordinated visits from children and any potential safeguarding concerns. Any concerns were discussed in the multidisciplinary team meeting so that plans could be made to support visits if appropriate whilst maintaining the child's safety.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. Care records were stored electronically. Staff logged into the system securely, and their entries were audited. Where paper records were used, these were then scanned into the system. Bank staff had access to the care record system, but agency staff did not. Bank and agency staff were provided with information about patients through the handover, which included key information about the needs, risks and care plan for each patient.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.

At the last inspection we issued a requirement notice for a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were occasions when medicines were out of stock which led to doses being missed, and monitoring of patients after rapid tranquilisation was not always carried out or recorded in patients' records. We also found that monitoring was not recorded/completed correctly when patients started taking clozaril, a medicine that needed careful monitoring. At this inspection we found that these requirements had been met.

An action plan had been implemented to ensure that the use of rapid tranquilisation was monitored to ensure the necessary checks post-administration checks were carried out. Each patient's physical health was monitored on and throughout their admission. This included following rapid tranquilisation, and when patients were started on clozaril. The nurse practitioner carried out a quarterly health check

of all patients on high dose antipsychotic therapy, and on patients prescribed lithium. The nurse practitioner was also a non-medical prescriber. The service had a clozapine analyser onsite, which sent the results directly to the pharmaceutical company so that further administration of the medicines was directly approved.

Overall the management of medicines had improved, and most medicines were stored and managed correctly. There were still some gaps in records, and occasions when medicines were not available. Storage of medicines varied across the wards. On some wards the medicine cupboards were overfull, so it was not easy to find individual medicines; some short shelf-life medicines did not have an expiry date, and medicine fridge temperatures were not always recorded or in range.

An external pharmacy supplied medicines, and a pharmacist visited and audited the site each week. The provider had noted an increase in medicine errors, and introduced an annual competency assessment for nursing staff. Some healthcare assistants had been trained to support qualified nurses to administer medicine.

Resuscitation and other equipment and medicines were available for use in the event of a medical emergency. The emergency medicine bags were routinely checked and sealed. Flumazenil, an antidote to benzodiazepine overdose, was not available at Arbury Court in accordance with Elysium's corporate policy. Nurses and medical staff were trained in immediate life support, and implemented this in the event of a medical emergency, and called the emergency services. Ligature cutters were available in areas that staff could quickly access.

Track record on safety

The service had a good track record on safety.

The service had 18 incidents that met their criteria for serious incidents in the year up to 4 April 2019. There were no deaths. Twelve of these incidents involved self-harm which was severe and/or resulted in attendance at an acute hospital. The remaining six incidents had no common themes. Primrose ward had the lowest number of serious incidents (one), and Delamere ward had the most serious incidents (six).

The most common incidents in the service related to self-harm, which included ingestion of foreign objects, cutting and creating/using a ligature. Risk was regularly reviewed throughout the service. We looked at a sample of incident investigation reports. They contained detailed description of the incident, and identified lessons learnt and this information was shared, but they tended to state the problem (for example, state that part of a policy had not been followed) but not identify the actual root cause of the issue. Staff had had training in investigation earlier in the year, but the service had identified there were still some quality issues and they were working to improve this.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had an electronic incident reporting. All staff had access to this, and knew how to report incidents. Completed incident forms were automatically sent to the ward manager, lead nurse, and hospital director, and to other relevant staff such as the health and safety lead. The service had a grading system for incidents. In the year up to April 2019 the number of incidents (across all levels) ranged from 376 on Cinnamon ward to 1542 on Delamare ward.

The incident reporting system was linked to the electronic patient record, and to the hospital's governance database. Incidents were routinely discussed in the daily management meeting. At this meeting decisions were made to determine if further action or information was required, or to sign off the incident or escalate it. Incident trends and specific incidents were reviewed in the monthly governance meeting, and any outstanding investigations or actions identified.

Information about incidents was shared with staff through several different routes including an email newsletter, regional and local governance, meetings, and team brief. Information following serious incidents is shared with heads of departments to disseminate to their staff. Information about incidents at other hospitals was shared.

Good

Forensic inpatient or secure wards

Staff told us that debriefs following incidents usually occurred, though this depended on the nature of the incident. This could be a short debrief at the end of a shift, or a discussion in reflective practice. Staff had access to a staff counsellor if they were distressed by an incident.

Information was available for staff about the duty of candour. Staff we spoke with were aware of the principles of the duty of candour.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

All patients had a comprehensive mental health assessment carried out after admission. Patients had a physical healthcare assessment after admission. Care plans and risk management plans were developed that reflected the assessments, and were individualised and recovery orientated to meet each patient's needs. The care plans were regularly updated by each patient's key nurse, and after the regular multidisciplinary team meeting. Patients in the psychiatric intensive care unit had their care plans reviewed at least every two weeks.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The psychology team worked across all the wards and provided mostly individual and group sessions. They provided a range of psychological therapies, depending on the needs and motivation of each patient. These included eye movement desensitisation and reprocessing therapy, cognitive behaviour therapy and schema therapy. There was a full programme of dialectical behaviour therapy which included two skills groups per week in addition to individual therapy sessions. Patients could participate in dialectical behaviour therapy preparation sessions, which included observing full sessions (with the permission of the patients involved), if they were uncertain about starting the full programme.

The occupational therapy team worked with patients and provided therapeutic and occupational groups. The occupational therapy team carried out an interest checklist with each patient, and led on education, fitness, and 'real-world' job opportunities.

Patients also had access to pet therapy, mindfulness, cooking, crafts and specific groups about substance misuse, money management and road safety.

The nurse practitioner led on physical healthcare in the unit. They carried out a full physical health check on admission, and repeated these at six monthly intervals. Patients were encouraged to participate in national screening programmes. Smear tests and flu jabs were provided onsite, and patients were supported to attend for breast screening through the NHS. The nurse practitioner was also the tissue viability and infection control lead, and provided wound care for patients. When patients swallowed or inserted objects, as a form of self-harm, there was a quick-access pathway with the endoscopy department at the local NHS hospital. There were healthy eating initiatives within the service, and patients were encouraged to eat healthier meals and snacks.

Speech and language therapy and dietetic advice and support was available when required. A speech and language therapist had completed communication plans for all patients with a learning disability or autistic spectrum disorder.

Good

Forensic inpatient or secure wards

The service used health of the nation outcomes scales to monitor outcomes for patients. Other rating scales were used by the different clinical teams which included the use of the model of human occupation by the occupational therapy team, and the Liverpool University neuroleptic side effect scales to monitor the side effects of medicine. The psychology team used various outcome measures with patients, but these were not collated, for example, to show the effectiveness of a therapy.

The service used a dashboard to monitor individual and service level progress. Information from care records and incident forms fed into the dashboard. This was used to monitor patients' attendance at groups/sessions and to monitor their progress. This included identifying the number of instances of an event, such as self-harm, and also any themes or patterns. Information in the dashboard was used to inform multidisciplinary team meetings, and as part of wider hospital discussions, from which care plans were then updated.

The service was in the early stages of introducing "safewards", a national initiative to improve safety and care on inpatient wards. This included pictures and information about staff, an activity wall chalk board, certificate wall for achievements of patients, and a self-soothe box for patients.

The service had carried out a green light toolkit assessment of its provision of care for patients with a learning disability or autistic spectrum disorder. Care and treatment reviews had been carried out for all patients with a learning disability or autistic spectrum disorder. These were usually carried out by three people, external to the provider, who reviewed every aspect of a patient's care and made recommendations if they felt improvements should be made, and reviewed if the hospital placement continued to be appropriate.

The Prescribing Observatory for Mental Health-UK and 'stopping over-medication of people with a learning disability, autism or both with psychotropic medicines' audits were completed annually for patients on the forensic wards.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Patients had access to occupational therapy, psychology and social workers who were directly employed by the service. Physical healthcare was led by the nurse practitioner, who was a non-medical prescriber.

All staff had an induction, which was a mix of corporate and local information. Clinical staff had accessed continuing professional development and training within and outside Elysium. Healthcare assistants were supported to develop their skills and experience through the career advancement programme.

Staff received regular clinical and managerial supervision. In the year up to 30 April 2019 85% of non-medical staff were up to date with their clinical supervision. Staff also had access to reflective supervision sessions which were led by the psychology team.

Up to 30 April 2019 84% of non-medical staff had had an appraisal within the last year. All five doctors at Arbury Court were up to date with their revalidation.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Representatives from all staff disciplines attended a daily meeting where information about patients and the service was shared. Nursing staff and healthcare assistants attended a handover meeting, and shared a handover document, at the beginning of each shift.

The nurse practitioner led on physical healthcare in the service. A GP carried out a surgery in the service once a week. Other health professionals provided regular sessions in the hospital. This included a dentist, optician and podiatrist. Speech and language therapy and dietetic input was provided when necessary, and other specialities had

provided services to patients when required. An ingestion of foreign objects pathway was in place, which was developed with the visiting GP and the endoscopy department at the local acute hospital.

Staff had effective working relationships with commissioners and acute hospital services. The social work team were the leads for safeguarding, and for links with families and carers. They had good working relationships with the local authority safeguarding team, and had contact with the police and probation services when necessary.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Mental Health Act training was mandatory for nurses, doctors and social workers. Over 95% of these staff had completed this training.

There was a Mental Health Act administration team on site, who provided advice and support for staff. There had been some errors in the administration of the Act, which had been identified by the provider and addressed. This included some consent to treatment forms which had not been completed correctly, but these were rectified during our inspection.

All patients at Arbury Court were detained under the Mental Health Act. They had access to an onsite independent advocacy service. Patients contacted the advocate themselves, or asked staff to do so. Patients in long term segregation or long term seclusion were automatically referred to the advocate by staff.

Patients had their rights under the Mental Health Act explained to them, and this was monitoring through the governance dashboard.

Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Patients in the service were usually detained under the Mental Health Act, and there had been no patients subject to Deprivation of Liberty Safeguards in the twelve months up to this inspection.

Each patient's capacity was discussed in the multidisciplinary team meetings. Patients were assessed for their capacity to make specific decisions, and supported to make these decisions where possible. Patients had access to an independent mental capacity advocate when required. When patients were deemed not to have capacity decisions were in made in a patient's best interest. Examples of this included patient's finances, treatment for physical health conditions, and future accommodation. Patients' families were involved in best interest discussions when appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory for nurses, doctors and social workers. Over 88% of these staff had completed this training. Staff understood the principles of capacity.

Are forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

The interactions we observed between staff and patients were positive and respectful. Staff provided patients with information and responded positively when patients were distressed. The feedback we received from patients – directly and through comment cards – was mostly positive. Patients found most staff to be responsive, helpful, friendly, kind and caring.

The patient satisfaction survey showed that there had been an increase in respondents from ten in 2017/18 to 22 in 2018/19, and there were improvements in most areas. An action plan was developed in response and included improving information provided on admission, knowing

who their buddy and care co-ordinator were, quality of food, information about side effects of medicines and having copies of care plans and care programme approach meetings.

Staff understood the needs of patients, and could describe their personal and health needs and how to support them. Staff felt able to raise concerns about disrespectful, discriminatory or abusive behaviour towards patients.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Patients received a welcome pack when they were admitted to the hospital. On some wards, patients were allocated a 'buddy' who was another patient on the ward. Patients were encouraged and supported to be involved in their care planning. Care plans were individualised and patient centred. Patients with communication difficulties had a communication care plan that was developed by or used information from a speech and language therapist.

Patients were involved in decisions about the service. This was part of the 'ward to board' governance structure. Patients were encouraged to attend community meetings, usually held weekly, on all the wards, though the attendance varied. Information from the meetings, and from individual patients, was fed into the patients' council by patient representatives. The patients council meeting was held monthly, and was attended by members of the management team. Patient representatives also attended part of the monthly hospital governance meeting. The hospital governance meeting was part of the broader Elysium governance structure. Concerns or ideas from patient meetings was fed into the wider meetings, minutes were taken and actions tracked, and information was then fed back through the meetings. Information was also displayed on each of the wards. Some wards had an "elephant in the room" board so that patients could raise concerns or suggestions by posting them on the board.

The service carried out regular reviews of restrictive practices and blanket restrictions, and these audits were supported by patients.

An independent advocacy service was based within the hospital. All patients were able to access this service, and patients in long term segregation or seclusion were automatically referred to the advocate. A dedicated complaints officer met with any patients who raised a complaint, and co-ordinated the response.

Staff informed and involved families and carers appropriately. Patients and their families were actively encouraged and supported to keep in touch with each other.

Patients in the forensic service were from across the United Kingdom, and may be at Arbury Court for several years. Patients in the psychiatric intensive care unit were also from across the country (usually England), but were in hospital for a much shorter period. This meant that friends and family were often some distance away from the patients. Patients were supported to keep in touch with their relatives. The nature of this varied according to the needs of and restrictions on the patient, and the distance and level of engagement with relatives. Some patients had regular skype calls to relatives who lived in other countries. Patients were supported to visit their families with staff escorts when required. Staff escorted and supported patients to visit relatives, for routine visits or for special occasions. The service offered information and advice to relatives who were travelling some distance, and in some cases provided practical and discretionary financial support to enable them to do this. This enabled patients to maintain contact with their relatives, when they otherwise would have been unable to do so.

The social work team led on engaging with patients' relatives, and were their key point of contact. Relatives were invited to care programme approach meetings and reviews of patients' care. The social work team at Arbury Court did not do carers' assessments, but they signposted carers to them. The hospital director piloted offering open drop in sessions to meet and raise any concerns, but uptake of this was low.

The service had a friends and family group, and from this a friends and family representative. The friends and family representative attended part of the hospital clinical governance group every three months. The friends and family representative also administered a text-message group, which was used by a small number of carers.

An information pack was available for relatives. This included details about the service, and practical information such as local hotels, supermarkets and

Good

Forensic inpatient or secure wards

restaurants. A carers' forum was held every other month, which combined information about the service with social events. For example, one event included information about medicines, the Mental Health Act, and items that were restricted because of the potential risk to patients.

There were visiting rooms in communal areas between the wards, and a child visiting room in the administration area. Some relatives had complained about problems with visiting the service at weekends. The main reception was closed at weekends, so visitors sometimes had to wait some time for a response from the wards when they arrived. Some visitors travelled long distances to get to the service, and refreshments were not always offered when they arrived if staff were busy. The service had responded to this by appointing a weekend visitor worker. The primary role of the weekend visitor worker was to promptly welcome visitors, communicate with the wards, and offer refreshments. Candidates for the post were being interviewed at the time of this inspection. The friends and family representative was on the interview panel, and the friends and family text-message group were invited to submit questions they would like to be asked.

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

(for example, to feedback?)

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

In forensic services, patients were admitted from across the United Kingdom, which included England, Wales and Northern Ireland. Services for English patients were commissioned by NHS England, and they visited the service to review patients every six weeks. Services for Welsh and Northern Ireland patients were commissioned by local NHS trusts, with their own arrangements for reviewing patients. Patients were usually admitted from other hospitals or from prison, and this was planned.

Services in the psychiatric intensive care unit were commissioned on an individual basis from services across the country. The decision to admit patients on the psychiatric intensive care unit was usually made by ward staff, and could be at short notice.

Patients were only moved between wards when this was justified on clinical grounds. The average length of stay of patients discharged from forensic wards in the 12 months ranged from 265 days on Appleton ward, 914 days on Oakmere ward, 1015 days on Delamere ward, 1198 days on Cinnamon ward, to 1247 days on Heathfield ward.

The psychiatric intensive care unit did not have a waiting list, and only accepted patients when a bed was available. The average bed occupancy in the six months up to 30 April 2019 was 63%. Patients were referred from across the country, so may be at some distance to their home. This decision was made by the referrer/commissioner. The average length of stay of patients discharged in the 12 months up to 30 April 2019 was 57 days. Patients were not moved from the psychiatric intensive care unit to the forensic wards.

The service had had two patients who had a delayed transfer of care in the year up to 30 March 2019. In both cases the patients had been waiting for a suitable alternative placement. The provider continued to discuss this with the funder of the service, and it was highlighted in the daily handover meeting.

Patients on the forensic wards had care programme approach meetings every six months, and progress towards discharge was routinely discussed and monitored in multidisciplinary team meetings, the daily hospital meeting, and in governance meetings. The service gave an example where a patient was ready for discharge, but this had been on hold because her local community team were not ready to provide support. Staff at Arbury Court agreed to temporarily provide outpatient care and support for a patient, so that she could be discharged, and would not remain an inpatient when this was no longer required.

Patients on the psychiatric intensive care unit were usually transferred back to their home area on discharge, or to a suitable placement.

The facilities promote recovery, comfort, dignity and confidentiality

Good

Forensic inpatient or secure wards

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

All patient bedrooms were single with an ensuite toilet and shower. Patients had personalised their bedrooms, and this was individualised depending on individual risk assessments. There was lockable storage within each patient's bedroom, and within the hospital, so that patients could still access potentially risky items under supervision. There was a laundry room on each ward, which patients had access to dependent on individual risk assessment.

Occupational therapists and activity co-ordinators worked on each of the wards, with support from other staff to provide activities. Patients had access to activity areas within the wards, and within shared areas between wards. This included lounge areas for watching television, quiet rooms, and general activity/meeting rooms. Patients used the occupational therapy department which included a gym, equipped music room, dance studio, and education room with internet access and a small library, and a hair and beauty salon. A qualified hairdresser was employed and provided hairdressing and beauty treatments/pamper sessions. Patients and staff were involved in events within the hospital. This included parties and initiatives such the promotion of clothes recycling.

A dedicated room was available for physical health care checks, which was also used for the weekly GP surgery.

Visitors were not allowed on the wards, but there were visiting rooms in shared areas between the wards. A family/child visiting room was in the administration block away from the wards.

There was access to outdoor space from each of the wards. This was open or restricted depending on the ward, and the assessed level of patient risk at the time. Patients could make a private phonecall on each of the wards. Smart phones, or phones with cameras, were not allowed on any of the wards, but non-camera phones were allowed on some wards. The use of either type of mobile phone was individually risk assessed for each patient's use either on the ward or when they went on leave.

The food was of adequate quality and patients had access to hot drinks and snacks at any time. Food was prepared and cooked onsite. Patients gave variable feedback about the quality of the food. They were able to give feedback after each meal, and through the patients' council where representatives from kitchen/facilities team attended. Each patient had their own supply of snacks. Patients had access to food and drink through the day and night. They had to request this from staff as most of the kitchens were locked, but this was risk assessed for each patient and ward.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships

Patients were supported to access services and facilities in the community, within the limitations of the Mental Health Act and Ministry of Justice restrictions. Patients were supported to attend college and work opportunities, which included working in the shop and caring for animals. Most of these were within the service, but some patients accessed these outside the hospital. At the time of this inspection, 20 patients were supported by the occupational therapy team to carry out a range of 12 "real work" opportunities across the hospital. Patients were supported on visits outside the hospital, which included days out to the seaside, and meals out in restaurants, as well as shopping trips.

Patients were encouraged to maintain contact and visit their families where this was possible. This included supporting families to visit the hospital, and supporting patients to visit their families.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

All the bedrooms were single and had an ensuite shower. There were bathrooms and a toilet that were accessible by people in a wheelchair. All the wards were on the ground floor, and on one level without stairs. All admissions were planned in advance, so any specific medical equipment that was needed could be arranged in advance.

Good

Forensic inpatient or secure wards

Information was available for patients in a welcome pack, and on display on the wards. This included information about their care and treatment, medicine, their rights under the Mental Health Act, advocacy and how to make a complaint.

Staff told us that most patients spoke English fluently. Several of the patients from Wales also spoke Welsh. Staff told us that some of the information leaflets had been translated into Welsh.

Food was prepared and cooked in the onsite kitchens. Special diets were provided when required, to meet dietary, religious or cultural needs.

There were several patients using the service who had a learning disability. All patients with a learning disability had received a care and treatment review. This is part of NHS England's commitment to ensuring services meet the needs of people with learning disabilities or autism.

The service was in the process of implementing a multi-faith room in the service. Patients had access to local spiritual leaders if required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service received 34 complaints in the year up to 29 April 2019, spread across all the wards. Thirteen of the 34 complaints were upheld, and none were referred to the Ombudsman. The key themes were related to patient property, two were related to patient care, and two were related to the attitude of staff.

Patients had easy access to a complaints process. Patients told us they knew how to make a complaint, and felt able to do so. There was information on display about the complaints process, and patients had access to an advocate to support them with their complaint if required. There was a complaint book on each of the wards, and a dedicated complaints officer who went to speak with patients directly about their complaints, and co-ordinated the complaint process. The initial response letter included a description of the complaints process and the timescales. Written responses to complaints included the outline of the investigation into the complaint, the outcome and any action that had been taken. Where relevant, information about complaints was fed back to staff, and any individual actions were raised in supervision.

Patients also raised general concerns and complaints in community meetings and through patient representatives at the patients' council meetings. There was "you said, we did" information on display on the wards.

Are forensic inpatient or secure wards well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Managers had the skills and knowledge to perform their roles, and felt able to raise their concerns and ideas for development. They felt supported by the wider organisation. Staff we spoke with were generally positive about ward and unit managers, and found them supportive and approachable. Management skills and leadership training was available for staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Elysium's values were: innovation, empowerment, collaboration, compassion and integrity. Elysium's philosophy was to deliver individualised evidence-based care, to support patients in their recovery journey. They were also committed to making families and friends an active part of each patient's recovery process and helping them to reach the end goal of more independent living where possible.

Staff we spoke with were familiar with the organisation's values. Throughout the inspection process we saw that

they were embedded in the care and support that was provided to patients. Staff told us that these were incorporated into interview questions and were repeated during induction.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff from all disciplines told us the wards could be very busy and stressful, and they felt there weren't enough staff, but most were positive about the teams they worked in and felt supported by other staff and managers. Most staff we spoke with said they felt able to raise their concerns with managers, and knew how to access the whistleblowing process. A monthly staff consultation meeting formally identified and responded to staff feedback and concerns, and these fed into the hospital and Elysium's governance process.

Staff had access to occupational health and an internal and external counselling service. There was a staff support lead and staff counsellor, who provided one-off and short courses of counselling for staff. The psychology team held regular reflective practice sessions, where staff could discuss complex patient care issues. The service provided an evolving range of wellbeing initiatives for staff. These included beauty/pamper sessions and staff awards and rewards such as having their birthday as a day off.

Managers dealt with poor staff performance when needed, and had support from human resources and other managers to do this.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The provider and the hospital had a clear governance structure. Information about this was provided to staff and was on the service's intranet. The governance structure was from 'ward to board', with a 'golden thread' to ensure a clear line of communication from each of the wards to the Elysium board. Information was shared from local patient, staff, management and governance meetings and through the regional structure up to board level. There were standing agenda items for each part of this, which fed into one another, and ensured information was shared both ways through the structure. These included ensuring that incidents and complaints were learnt from, monitoring and responding to information from the computer dashboard and audits, and implementing service developments and improvements.

The computer dashboard was a key part of the governance structure. The information, which included links to the electronic care records and incident reporting system, was shared and used to inform the governance process. Specific incidents and events over the last day/weekend were discussed at the daily management meeting. Actions were identified and followed up at subsequent meetings.

The monthly hospital governance meeting included a review of all incidents and the use of restrictive interventions over the last month. The 'live' dashboard was reviewed, and could be dynamically looked at to identify patterns and trends. For example, if there had been an increase in the number of restraints the reasons for this were discussed, and a comparison could be instantly generated to see if the increase was a one-off, a continuing trend, or a repeated increase in relation to the time of year or a specific event.

Overall, the governance framework worked well. The process for reviewing clinical and non-clinical risk was detailed and responsive. Maintaining the quality and quantity of staffing within the service remained a challenge, but managers were proactive in their ongoing recruitment and retention strategy, which included wellbeing initiatives for staff. There was routine monitoring and reviewing of staffing levels, and it was clear that there was an understanding of the needs of the patients, the staff working within it, and how best to meet that with the resources available. The service was focused on recovery and least restrictive practice, which it balanced against the challenge of keeping people safe. However, there were some areas where gaps had been found. This included the monitoring of the implementation of the Mental Health Act, the management of medicine, and the quality of some incident reports. The provider had identified issues with some of the incident reports and provided training for staff.

This had shown improvements in the quality of the incident reports, but some of the reports still did not show an embedded understanding of how to identify the root causes of an incident in order to learn from this.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers had access to the local and provider-wide risk registers. These were routinely discussed at the hospital's clinical governance meetings. Managers could identify issues they wished to escalate. Clinical and other risks were discussed routinely, through the daily management meeting, and through the hospital governance system.

The service had contingency plans in the event of emergencies. These took account of the security of the service, and potential clinical risks. The service carried out periodic fire and medical emergency drills.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The electronic care record system was accessible to permanent and bank staff, through a secure login and password. Bank and agency staff were provided with information about patients through the handover, which included key information about the needs, risks and care plan for each patient.

The service's electronic care record and incident reporting database was linked to the provider's clinical governance system. It produced a 'dashboard' that enabled information to be shared and monitored for different purposes within the organisation. For example, the number of hours of activity a patient had participated in and one-to-one sessions with their key nurse were routinely monitored, and if the set target had not been met this was followed up. Information within the dashboard was used to inform care on the wards, and to monitor performance across the hospital. Information in the dashboard was also used to identify themes and monitor trends within the hospital. For example, changes in the number or type of restrictive interventions. If action was taken to address areas of concern, then the dashboard was used to monitor if improvement had occurred, or if further action was needed. Information in the dashboard was updated daily, so showed current trends. Reports could be generated to compare information by individual, ward, hospital, or across different time periods.

The service provided performance reports to its commissioners, and notified the relevant statutory bodies as necessary. This included commissioners, the local authority safeguarding team, and the Care Quality Commission.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Patients, staff and carers receive information about the service. This included through the service's website, emails and electronic newsletters, and paper copies of information about the service and ways to engage with it. Staff had access to the trust's intranet. Information was on display across the site. This included information about the service, staffing levels, and performance.

Patients and carers fed back about the service thorough the corporate patient survey and the friends and family survey. They could also feedback directly through local meetings, groups and representatives.

Patients, carers and staff each had their own meetings, where they had formal access to senior managers. These were through the patients' council, the carers group and the staff consultation group. Representatives from these groups, and the minutes of meetings, fed into the hospital governance meetings. Through this patients, carers and staff could raise concerns and make suggestions for improvements, and managers could receive information about changes and developments within the service, and

Commissioners of the forensic services, such as NHS England and NHS trusts in Wales, visited the service regularly to review their patients, and met routinely with senior managers.

Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities.

Good

Forensic inpatient or secure wards

The forensic wards were part of the Royal College of Psychiatrists Quality Network for Forensic Mental Health. This is a nationally recognised network or services who peer review each other against a set of standards for low and medium secure services. The most recent review was in October 2018, and met 87% of the medium secure standards and 85% of the low secure standards. This had improved since the previous review.

The service had initiated an external review of restrictive interventions, to get an independent view of its use of restrictive interventions and what it could do to reduce them, and use alternative strategies. The report for this was in progress at the time of this inspection. This was in addition to the service's routine review of restrictive interventions.

The service was in the early stages of developing restorative justice work. Staff had completed training, and some work between patients had been carried out.

Outstanding practice and areas for improvement

Outstanding practice

Patients, and carers, were an integral part of the service's governance. Each ward, where possible, had a patient representative who attended the ward community meetings, the patients' council, and the hospital governance meetings. Relatives were also encouraged to be part of this, and there were carers' groups and events, and a carers representative.

Relatives were actively encouraged and supported to maintain contact with patients, even if they lived at distance from the service. This included providing practical and discretionary financial support to some families, who would otherwise not be able to see their relatives.

Staff at Arbury Court had provided outpatient care to a patient, in order to facilitate her discharge, and prevent her continuing to be detained in hospital.

An ingestion of foreign objects pathway was in place, which was developed with the visiting GP and the endoscopy department at the local acute hospital.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there is robust monitoring and auditing of the paperwork associated with the Mental Health Act.
- The provider should ensure that the implementation of investigations into incidents, such as root cause analysis, is completed effectively.
- The provider should ensure that the management of medicines is carried out correctly.
- The provider should ensure that when patients are unable or unwilling to participate in the development of positive behaviour support plans, alternative methods are used to determine the meaning behind the patient's risk behaviours.