Cygnet NW Limited

Cygnet Hospital Sheffield

Inspection report

83 East Bank Road
Sheffield
S2 3PX
Tel: 01142793350
www.cygnethealth.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

- The service provided safe care. The ward environments were safe and well maintained. The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely and followed good practice with respect to safeguarding. They minimised the use of restrictive practices and worked collaboratively with patients towards reducing restrictive practices.
- 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 audits 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 staff received continuing development of their skills, competence and knowledge; providing training, supervision and appraisal. All staff were committed to working collaboratively as a multidisciplinary team to provide consistent high-quality care, as well as liaising with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- 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. The young people, in particular, were truly respected and valued as individuals and empowered as partners in their care.
- Services were tailored to meet the needs of individuals, and the hospital had created a safe and inclusive environment for LGBT patients. Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The service was well led and the governance processes ensured that ward procedures ran smoothly.
- There were examples of outstanding practice within the child and adolescent mental health service (CAMHS) wards.

However,

- The hospital did not always follow best practice with regards to medicines management and application of the Mental Health Act 1983. There was not always clear information management within patient records or incident recording for the adult wards; and although the hospital was working to reduce incidents across the hospital, there was a high number of self-harm incidents on the CAMHS wards. The service did not have consistent quality of staffing from day to night.
- The discharge care plans were not always reflective in the adult services and the patients reported that food was not of a good standard.
- The provider did not always resolve environmental concerns in a timely way and the hospital's cleaning processes were not always robust.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Good 	Our rating of this service improved. We rated it as good because: • The ward environments were safe and well maintained. The wards had enough nurses and doctors. Staff assessed and managed risk well, had low use of medicines, and followed good practice with respect to safeguarding. The service had a comprehensive strategy focused on minimising the use of restrictive practices, they placed trust in the young people, who were actively involved in managing their own risks. • Staff developed a truly holistic approach to assessing, planning and delivering care and treatment to all people who use services, 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 audits 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 staff received continuing development of their skills, competence and knowledge; providing training, supervision and appraisal. All staff were committed to working collaboratively as a multidisciplinary team to provide consistent high-quality care to the young people, most notably with the school staff; as well as liaising with those outside the ward who would have a role in providing aftercare. • Staff understood their responsibilities under Mental Capacity Act 2005 and followed good practice with respect to young people's competency and capacity to consent to or refuse treatment. • Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, families and carers in care decisions. • Services were tailored to meet the needs of individual people and delivered in a way to ensure

Summary of findings

flexibility, choice and continuity of care. They celebrated individuality and created a safe and inclusive environment for LGBT patients and those with protected characteristics. Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The service was well led and the governance processes ensured that ward procedures ran smoothly.

However,

- There was a disparity in the quality of care provided during the day and night due to an increased reliance on agency staff in the evenings and there was a high number of self-harm incidents across the wards. Medicines management and stock processes were not always effective. Cleaning processes were not always thorough on the wards.
- Staff did not always follow best practice when discharging their roles and responsibilities under the Mental Health Act 1983.
- The information management systems in place made some patient documentation complex to track.

Forensic inpatient or secure wards

Good

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

- The service provided safe care. The ward environment was clean. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, 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 audits to evaluate the quality of care they provided.
- The ward team included or had access to the full range of specialists required to meet the needs of

Summary of findings

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, families and carers in care decisions.
- 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.

However,

- The provider had not taken timely action to reduce all environmental risks. Staff did not consistently document incidents, as debriefs were not always recorded.
- The discharge care plans were not always reflective of the work being undertaken or carer input. Patients reported that food was not of a good standard and did not meet their nutritional needs.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospital providing child and adolescent mental health services (CAMHS) for male and female adolescents aged between 12 and 18 years old and low secure services for women aged over 18. Patients are admitted from across England and the hospital provides care and treatment for informal patients and patients who are detained under the Mental Health Act 1983.

The hospital had four wards:

- Pegasus, a 13-bed mixed sex acute mental health ward for children and adolescents;
- Unicorn, a 10-bed mixed sex psychiatric intensive care unit for children and adolescents;
- Griffin, a 12-bed mixed sex low secure ward for children and adolescents; and
- Spencer, a 15-bed low secure ward for women.

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection. (A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have the legal responsibility for the service meeting the requirements of the Health and Social Care Act 2008 and associated regulations. An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.)

Cygnet Hospital Sheffield is registered with the Care Quality Commission to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

We last undertook a comprehensive inspection of Cygnet Hospital Sheffield in August 2017. The hospital did not meet three regulations of the Health and Social Care Act (Regulated Activities) 2014. We issued requirement notices in relation to the HSCA (RA) Regulations 2014; Regulation 9 (Person-centred care), Regulation 16 (Complaints) and Regulation 17 (Good governance). The hospital was rated as requires improvement in all five domains.

Between our last comprehensive inspection in 2017 and this inspection, we have completed five focussed inspections of Cygnet Hospital Sheffield. We found that the provider had made improvements and worked to rectify the breaches in Regulation identified during the comprehensive inspection.

The most recent focused inspection took place in May 2020, in response to a whistleblowing and concerns about patient safety on the CAMHS wards. We identified one breach in Regulation 17 (Good governance). We stated that the provider must maintain an accurate, complete and contemporaneous record of care and treatment provided; ensuring there is a clear care plan for as and when required medication. We reviewed this breach during this inspection. The provider had made improvements to their documentation and there was a clear care plan in place relating to patient's medication and the use of as and when required medication.

What people who use the service say

Summary of this inspection

We spoke with 17 patients and 13 family members or carers of people using the service. Feedback about staff approach was largely positive, with patients describing feeling well cared for. Many young people on the CAMHS wards informed us it was the best placement they had experienced. Patients particularly noted that the multidisciplinary team was skilled, consistent, and fair. Patients and carers described the progress that patients had made while in the service and steps that were being taken towards discharge.

Staff supported patients to maintain contact with their families and friends; and carers felt involved in the care of their loved ones and the use of technology enabled them to be involved in meetings. They felt their views were listened to and respected. Carers felt welcome and confident to raise concerns if they had any.

However, both young people and their carers told us that increased agency use in the evenings impacted upon the quality of care on the CAMHS wards. On the forensic ward, two patients and one family member raised concerns about the lift being broken.

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 a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 17 patients who were using the service;
- spoke with 13 family members or carers of patients who were using the service;
- spoke with all four ward managers, the hospital director, clinical manager and CAMHS lead;
- spoke with 45 other staff members including nurses, mental health support workers, lead support staff, agency staff, student nurses, physical health staff, consultant psychiatrists, speciality doctors, clinical psychologists, social workers, reducing restrictive practice lead, quality lead, occupational therapist, assistant psychologist, Mental Health Act administrator, maintenance staff and domestic staff;
- spoke with the headteacher and the pharmacist from partnership agencies;
- reviewed seven comment cards from staff, young people and carers from Griffin and Pegasus ward;
- observed two handovers, two community meetings, one daily situation report meeting, one information governance meeting, one ward round, one care programme approach and an art therapy session;
- looked at 18 care and treatment records of patients, six seclusion records and two long-term segregation records;
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The team that inspected the service comprised of four CQC inspectors and a CQC Mental Health Act reviewer; three specialist advisors who were social worker, consultant psychiatrist and nurse professionals; and one expert by experience.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice within the CAMHS wards:

- The hospital encouraged feedback from carers and young people and used this to improve the quality of care. Young people had spearheaded the inclusion of activity workers as part of the hospital's reducing restrictive practice strategy. Carers' feedback had led to the introduction of the lead support roles to provide a family liaison function, updating relatives twice weekly and giving parents a single point of contact to assist with continuity. The role was also subject to a national evaluation commissioned by the provider to inform longer term changes. The young people were respected partners in improvement and innovation within the hospital and their influence was evident in multiple aspects of the hospital's provision; including the safe hosting of the hospital's first prom event during the pandemic, environmental improvements and even the supervision tracker used by management. Patients had also been involved in environmental reviews to assess the safety and suitability of other CAMHS wards within the organisation prior to them opening.
- The hospital had created a positive and inclusive culture on the CAMHS wards. The hospital had excellent LGBT support for young people. The hospital was proud that their staff team was representative of their patient group and staff modelled an inclusive approach and were creative in approaching individual needs. They were mindful of young people's preferred names and pronouns in care records, community meetings and room placements, and hosted celebratory Pride events. Young people were encouraged to celebrate their talents and some had used this to personalise the wards and their bedrooms with murals and paintings, many of which contained rainbows and other positive and inclusive imagery.
- The senior managers had been creative in their recruitment and retention strategies; sponsoring local sports teams, training staff to be trauma risk management practitioners to offer staff support, investing in a diverse range of training opportunities and creating new roles for senior support workers to progress into. This had reduced the turnover rates within the hospital and allowed them to staff the hospital to 112% capacity, a figure they aimed to increase to 140%.
- Unicorn ward had also been the first psychiatric intensive care unit in the country to achieve CAMHeleon accreditation, a model designed by Star Wards, and the hospital was working to embed this on the other two wards.

Areas for improvement

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

Cygnet Hospital Sheffield

- The service should ensure that good quality food is provided, that meets the nutritional needs of the patients.

Summary of this inspection

CAMHS wards

- The provider should ensure that Mental Health Act processes are carried out in line with the best practice.
- The provider should ensure that their documentation processes are not complex for staff and that patient information is clear and easy to track.
- The provider should ensure that they appropriately monitor medicines including stock management, and clinic room processes.
- The provider should ensure that a consistent quality of care is provided and the use of temporary staff does not impact negatively on young people.
- The provider should ensure that cleaning processes are thorough and robust across all wards.
- The provider should continue with their work to reduce self-harm incidents on the wards.

Forensic inpatient or secure wards

- The provider should ensure that action is taken in a timely way to mitigate environmental risks.
- The provider should ensure that debriefs after incidents are consistently recorded.
- The provider should ensure that families and carers are included in discharge planning and that discharge care plans reflect the work being undertaken.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Good

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

Safe and clean care environments

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. They involved the young people on the wards in audits in order to identify further risks and means of mitigating these.

Staff could observe patients in all parts of the wards. They utilised closed-circuit television, convex mirrors and staff observations to mitigate any limited visibility areas.

The ward complied with guidance to manage mixed sex accommodation on all of the wards. Should patients not wish to be on a mixed ward, this would need to be discussed with the patient's commissioners. Non-binary and transgender patients were able to have flexibility to have bedrooms wherever they were most comfortable.

Staff had easy access to alarms and patients had easy access to nurse call systems, which were present in all bedrooms as well as communal spaces.

Maintenance, cleanliness and infection control

Ward areas were well maintained, well-furnished and fit for purpose. The hospital had introduced a rolling process of redecoration to ensure that the wards remained tidy and up to date, Pegasus and Griffin wards had been completed at the time of inspection.

The wards were regularly cleaned and staff made sure cleaning records were up-to-date. However, one of the young people's bedrooms had mould on the sealant of their shower. Two patients also informed us that some areas were not always cleaned thoroughly, including following incidents and evidenced this during inspection. Another patient also

complained about bugs in the light fixtures. We were informed by the hospital that insects in the light fixtures were a seasonal issue that was addressed by maintenance staff. Patients told us that staff would address additional cleaning requirements if raised and one of the young people also informed us that they were supported by staff to carry out additional room cleans for their bedroom.

Staff followed infection control policies, including handwashing. The hospital had clear Covid-19 processes that were observed to be followed throughout inspection. Unicorn ward had also appointed two young people as Covid monitors to provide additional checks, they challenged any lapses in process that they observed and produced daily audits.

Seclusion rooms

Both Griffin and Unicorn wards had seclusion rooms. These allowed clear observation and two-way communication, temperature control and had visible clocks. They had toilet and shower facilities.

Each ward also had extra care areas with a lounge separate to the bedroom and en-suite area, a TV, activities and books. Unicorn and Griffin had recently renovated their extra care areas and Griffin's also had access to its own garden. Young people spoke positively about these spaces and had been able to personalise them.

Clinic rooms and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment in multiple sizes and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had no vacancies. The hospital director had introduced several innovative recruitment and retention schemes that had resulted in a rise in their staffing figures. The hospital had achieved 112% staffing levels at the time of inspection, which was over the planned establishment for the service.

The service also had reducing turnover rates. Between June 2020 and June 2021, the hospital's overall turnover had reduced by 46% from the previous year. The turnover figure, without the inclusion of bank staff, was 23% for the period. Turnover was predominantly among support workers, with much lower figures among all other professions; this figure rose to 42% with the inclusion of bank staff who had left the service.

However, despite these high staffing levels, the service continued to have high rates of bank and agency nurses and health care assistants. From our review of the rotas and situation report data from July to September 2021, the wards were regularly staffed above their baseline figures to account for activities, observations and ward acuity.

Staff, families and patients told us that the use was higher during evenings and weekends. From reviewing the rotas, it was clear that while there was fewer permanent staff on the night shifts, this was not routinely the case at the weekends. We were informed by patients and their families that there was a disparity in the quality of care provision when there

were higher rates of agency staff and that some agency staff were less attentive and respectful than regular staff, impacting on the quality of care for young people. However, young people informed us that staff would facilitate a change of evening duties to ensure that they had a familiar member of staff to facilitate one to ones. The hospital managers aimed to staff the hospital to 140% establishment levels to try to further reduce the use of agency staff. The hospital managers had also introduced night checks to address claims that the night shifts were less effectively staffed. Four senior managers attended the site at the same time, with one attending each ward, to check that the wards were compliant with their expected care standards, including engagement with young people and observation practices.

Managers had tried to limit their use of bank and agency staff and requested staff familiar with the service. They had employed a number of bank and agency on extended contracts and had hired familiar and skilled agency staff as permanent staff where possible.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health and those who had been assaulted or been involved in difficult incidents.

Levels of sickness had been higher than usual in the months prior to inspection, they had had a number of staff calling in at short notice as they had been alerted that they had come into contact with somebody who had tested positive for Covid-19. This had improved at the time of inspection.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The base staffing figures was eight staff for Griffin and Unicorn ward and six staff for Pegasus, with two nurses allocated and the remainder of staff being support workers. We were informed by ward managers that they were supported by the hospital managers to increase their staffing figures to meet the needs of the wards, even if this sat outside of their staffing matrix, and that their judgement was trusted and validated by the senior leaders at the hospital. This was evidenced within the staff rotas which were routinely above the baseline numbers and were observed to be as high as 17 staff on Griffin, 15 staff on Unicorn and 10 staff on Pegasus during the month of inspection in response to observations, patient numbers and ward acuity.

The ward manager could adjust staffing levels according to the needs of the patients. The managers attended a situation report meeting every weekday to discuss the staffing levels across the hospital. there was evidence within the meeting minutes as well as the meeting we attended during inspection, that they had moved more experienced staff between wards to ensure that there was a suitable skill mix on all wards.

Patients had regular one to one sessions with their named nurse. There was evidence within patient records of young people having regular one to ones with multiple staff disciplines.

Patients rarely had their escorted leave, or activities cancelled, even when the service was short staffed. The hospital kept a log of when this had occurred and incident reported it. Young people informed us that this had improved since the activity coordinator roles had been introduced and that activities and leave could be rearranged due to ward acuity, but rarely cancelled.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. This included when young people attended school, there was always a school representative present during handover.

Good

Child and adolescent mental health wards

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Each ward had a CAMHS consultant and a speciality doctor.

Managers could call locums when they needed additional medical cover though this had not been necessary due to the permanent staff they had in post.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All mandatory modules had compliance rates of over 80% for each ward and the overall mandatory training compliance for each ward was above 90%. The hospital regularly monitored their training figures and provided staff with protected time in order to keep up to date.

The mandatory training programme was comprehensive and met the needs of patients and staff. This included the school staff, who completed the same mandatory training as the hospital teams.

Managers monitored mandatory training and alerted staff when they needed to update their training. They also spoke with the staff teams following serious incidents and updated their training requirements in response to feedback. For example, the intermediate life support training was increased from 12 to six-monthly following a serious incident; not through any fault identified within the investigation, but in response to staff saying it would improve their confidence.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. The hospital also produced a daily risk assessment as part of the handover process, this applied a red amber green rating to the young person's risk and would give a summary of the current risks for that patient and management plan, alongside their observation level and leave status.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. A proactive approach to anticipating and managing risks to the young people who used services was embedded and was recognised as the responsibility of all staff. Staff at all levels were able to discuss individual patients' risk management strategies.

Staff identified and responded to any changes in risks to, or posed by, patients. This was approached as a multidisciplinary team and the wards applied a responsive approach to assessing and managing patient risk.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There was evidence within patient care plans of search processes being personalised to individual patient risk. They had recently adapted how they search patient clothing and introduced new metal detectors to the wards following an incident review in which some metals had not been picked up by the previous wands.

Staff were able to discuss risk effectively with people using the service and young people were actively involved in managing these risks. The hospital had a strong focus on positive risk taking, which was spoken about proudly by both

staff and patients. Blanket restrictions, such as the hours that the gardens were openly accessible, were documented within a log and discussed within community meetings and staff took an open approach to considering patient challenges to these. Young people told us that they were given a lot of trust and this helped their progression. For example, the wards had real plants in ceramic pots on the wards, young people had access to smart phones and the internet, young people had access to wool and crochet hooks, and an open fridge was placed in communal areas. A collaborative risk management plan and ward expectations were put in place to discuss how they would manage these risks and individual risk assessments were in place where applicable. This approach had a positive impact on the ward environment and therapeutic relationships; this was particularly true of Griffin ward, a low-secure environment.

Use of restrictive interventions

Levels of restrictive interventions were reducing. Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm. The ward managers produced a monthly document of the ward's figures and themes to be discussed within local governance meetings. There was also a dedicated forum within the positive and safe meetings and local clinical governance to analyse the data and discuss the service's strategies towards reducing this further.

The reducing restrictive practice lead had compiled reducing restrictive practice folders for each ward. This detailed data for the ward and measures introduced to try to lower these. The young people on the wards were given anonymised data packs to highlight types of incidents as well as riskier days and times. This was then discussed within the young people's council and strategies were compiled to try to address this. The young people produced presentations of these strategies for the management team, and following this activity coordinators were introduced across evenings and weekends as these had been identified as higher risk periods.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The reducing restrictive practice lead and clinical psychologist had delivered training to all staff in working with traumatised individuals and reducing restrictive practices. Following this training the hospital had seen a decline in the use of restraint, particularly on Griffin ward; one young person had reduced from 30 incidents of restraint in the month to five.

Between January and August 2021, the child and adolescent mental health service (CAMHS) wards had reduced the use of restraint from 249 incidents in the month to 159 and the use of rapid tranquilisation had reduced from 28 to 14. There had been a small reduction in the use of seclusion, from eight to six, and the use of long-term segregation had remained at 2.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients told us that the use of restraint had been necessary and dignified and they had received a debrief afterwards. The use of restraint was audited by the reducing restrictive practice lead and the head of security (a restraint trainer). They reviewed a random selection of incidents on each ward and identified lessons learned. They had also provided personalised restraint techniques for individual patients.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect young people and staff from harassment and discrimination, including those with protected characteristics under the Equality Act. The hospital's social workers took an active role in the ward's multi-disciplinary team and safeguarding was discussed daily alongside risk.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. There was clear collaborative working with the local authority as well as young people's community social workers. The young people's care plans had a safeguarding section with relevant management plans detailed according to their individual needs.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The wards had dedicated social workers who were key members of the multidisciplinary teams. There was evidence from young people's files of regular safeguarding referrals and plans being made.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Patient notes were comprehensive and all staff could access them easily. Contracted agency staff had their own log in details and the full multi-disciplinary team, including school staff, could make entries within patient daily notes and had access to their care plans and risk assessments.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. They scanned paper copies of paper documents, such as seclusion records, onto the shared drive in a timely manner. However, information was not always kept in the same place making some data difficult to track.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. They employed an external pharmacy to conduct weekly audits of these processes, reports were sent through to the ward manager and an electronic portal was updated with actions which allowed senior ward staff to directly respond to the pharmacist.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients care plans included a medicines section that detailed which medicines had been prescribed and possible side effects; including in relation to as required medicine, which had been a concern raised at the last inspection. Both young people and carers were able to give examples of instances in which medicines had been changed at their request.

Good

Child and adolescent mental health wards

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. We found that the clinic rooms were overstocked and there were multiple medicines stocked that were not prescribed for any of the patients currently on the ward. All medicines were stored correctly and were in date. We were informed by staff and the pharmacy that the ordering processes could be improved upon to avoid duplication. Unicorn ward had a controlled drugs book which did not have a ledger, which would be in line with good practice, this was rectified on the day of inspection. The sharps bin had also not been signed or dated with the time of opening, and the fridge temperature had been high on seven occasions between 1 June 2021 and the time of inspection on Unicorn ward, this had also occurred on five days on Pegasus. We were informed that the hospital was very responsive to any actions identified within audits, with evidence provided, and that they were engaged in improvements and training provided by the pharmacy.

Staff followed current national practice to check patients had the correct medicines. In addition to the pharmacy checks, the hospital had a peer review process whereby the consultant psychiatrists would review the prescribing practices from other wards and were able to challenge practices. We noted during inspection that the use of medicine and as required medicine was low across all three wards.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. This was supported by an external pharmacy that attended the site weekly.

Decision making processes were in place to ensure the young people's behaviour was not controlled by excessive and inappropriate use of medicines. As part of the reducing restrictive practice initiatives, the young people had designed one-page profiles. These were placed at the front of their medicines cards, the observation boards, the handover document, as well as in the young people's bedrooms to ensure that staff were aware of warning signs and how best to respond. The service noted that there had been a reduction in the use of as required medicine since these had been introduced, which was supported by the low use observed during inspection.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. However, the recording of this was not consistent. For example, one patient's physical health observations were stored on their national early warning score form, daily notes and an incident form across different days. This made it difficult to track whether checks had been consistently completed.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy.

The hospital recorded a high number of incidents across the CAMHS wards. They recorded 494 incidents in the month prior to inspection; 324 were listed as no harm, 164 were listed as minor harm and the remaining six were listed as moderate harm. Of these, 272 related to self-harm, there were 99 incidents of violence and aggression and three reported medicine errors. The multidisciplinary team reviewed these monthly within the positive and safe and the local clinical governance meetings. The ward managers produced a monthly report to highlight themes and learning to be discussed within these meetings.

Good

Child and adolescent mental health wards

The service had no never events on any ward; but one unexpected death had taken place on a CAMHS ward in the six months prior to inspection.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff of all levels reported that they felt very supported by managers within the hospital. Maintenance staff who had witnessed a self-harm incident informed us that they had had debriefs as well as support from the ward psychologist following the incident. Staff continued to have access to support and psychology sessions following the unexpected death that had occurred six months prior to inspection. All staff spoken with said that the management team had been compassionate and caring in their response.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and they had received positive feedback from families about their carer involvement and communication with this difficult process. Lessons learned included improving engagement of patients in debriefs if they had declined following incidents, young people were involved in a review of the debrief process at the time of inspection.

Staff received feedback from investigation of incidents, both internal and external to the service. These were shared as "red top alerts" that were sent via email, discussed within team meetings and printed and put up in the staff offices. Staff spoken with were able to discuss changes and improvements made as a result of these.

Staff met regularly to discuss the feedback and look at improvements to patient care. They also met regularly with the young people to discuss their ideas for improvement.

There was evidence that changes had been made as a result of feedback. All staff spoken with, including multidisciplinary, maintenance, and domestic staff, were able to give examples of improvement initiatives that had been made on the wards following incidents and feedback. For example, additional measures had been brought in to check tools used by maintenance staff on and off the ward.

Managers shared learning about never events with their staff and across the provider.

Managers shared learning with staff about never events that happened elsewhere within the monthly local clinical governance meetings, team meetings and email alerts. Staff were able to give examples of how this had been used to inform changes to their practice, such as including low level ligature risks within the environmental risk assessments.

Are Child and adolescent mental health wards effective?

Good

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

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Good

Child and adolescent mental health wards

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Each ward had two physical healthcare support staff and there was a physical health lead for the service who worked closely with the speciality doctors and was responsible for auditing physical health practices.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed nine care records during inspection, these were comprehensive and covered multiple aspects of patient care, including social needs.

Staff regularly reviewed and updated care plans when patients' needs changed. They were updated as a minimum of weekly, following the young person's ward round and updated to reflect current risks and risk management strategies.

There was a truly holistic approach to assessing, planning and delivering care and treatment to all young people who used services. Care plans were personalised, comprehensive and recovery-orientated. There was clear evidence within all care records reviewed of patient involvement, with individualised interventions listed and frequent quotes from patients within them. They listed patients' preferred pronouns and names, they were very individualised, and all young people spoken with reported feeling involved in their care and treatment decisions.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. The clinical model had recently been updated, the young people had been involved in this and the proposed model was sent out to families to comment as well.

Staff delivered care in line with best practice and national guidance from relevant bodies such as NICE.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. Each ward had two physical healthcare support workers and a speciality doctor who worked with the hospital's physical health lead to support young people's needs. The hospital also had the support of an external urgent care practitioner when required. Staff were able to give examples of working with external organisations, such as a diabetes team and specialist nursing to ensure patients were receiving the correct support.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had a gym and basketball area, they had support of a fitness support worker and an external trainer who came in to do boxing with the young people weekly, which was spoken about highly by the young people involved. The hospital also had an allotment that young people were involved in maintaining. The adjoining school, in conjunction with the hospital, had recently been awarded the John Muir award, an environmental award scheme focused on wild places.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. They used Health of the Nation Outcome Scores as well as a daily risk assessment which provided a red amber green rating to risk and was monitored through multidisciplinary reviews and within information governance meetings.

Staff used technology to support patients. All wards had allowed access to smart phones for patients, where risk assessed as appropriate, and wards had access to tablets for the young people to use. The school utilised virtual conferencing where possible with the young people's community schools to allow them to continue with specific modules.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff completed monthly audits in patient records, hand hygiene, observation and closed-circuit television and the Mental Health Act; they also completed medicines audits following the use of rapid tranquilisation and six-monthly audits of ligature assessments and blanket restrictions. The service's quality lead was responsible for compiling these and worked with the wards towards improvements.

Managers used results from audits to make improvements. The results of audits were reviewed within monthly governance meetings as a multidisciplinary team.

Skilled staff to deliver care

The service had a full range of specialists to meet the needs of the patients on the ward; this included social workers, occupational therapists and assistants, assistant and clinical psychologists, family therapists, a speech and language therapist, and an art therapist. The multidisciplinary input was discussed positively by staff and young people alike who stated that the treatment provided was effective, interesting and creative.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. All new starters had already been enrolled to receive three modules in CAMHS care with a university as part of their induction, the equivalent of a certificate of higher education, but this had recently been extended by the hospital. All staff who didn't have an existing degree could now apply to achieve a degree to become a CAMHS specialist, or achieve their nurse training, with an accelerated course available for staff with an existing degree (with these courses funded by the hospital). This extended up to a leadership and management qualification that was the equivalent to a master's degree for those who wished to progress to a management role. Staff could also complete their nursing apprenticeship while maintaining a full-time wage.

Managers gave each new member of staff a full induction to the service before they started work. Staff were clear that they would not pass probation if they had not completed the full induction and passed all mandatory training modules. An expert by experience had recently been introduced to the induction process to give new starters an insight into their perspective. The young people had also created a welcome bag of items with motivational messages assigned such as sweets "because we appreciate all the hard work you do" and a paperclip "so you can hold yourself together through challenges".

Managers supported permanent non-medical staff and medical staff to develop through yearly, constructive appraisals of their work. Each ward had an appraisal compliance rates of between 98-100%; allied health professionals and non-clinical staff had compliance rates of 100%.

Managers supported non-medical and medical staff through regular, constructive clinical supervision of their work. Each ward had a supervision compliance rate of above 90% at the time of inspection.

Managers made sure staff attended regular team meetings or shared information from those they could not attend.

Managers identified any training needs their staff had and made sure staff received any specialist training for their role. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. Two staff members had completed working with young people with autism train the trainer courses and were training all staff across the wards in this within a three-day training package. One of the speciality doctors was rolling out wound care training to staff to reduce reliance on accident and emergency teams following self-harm incidents. The hospital had trained staff to be trauma risk management practitioners, qualified to identify signs of distress in people to support staff and young people. One nurse from each ward was also to be trained as a CAMHS advocate.

Managers recognised poor performance, could identify the reasons and dealt with these. Staff informed us that they were open to raising concerns about staff performance, addressing changes to the use of restraint in the moment and approaching management for concerns regarding conduct.

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All meetings involved the different professions involved in patient care, there were strong links and a seamless approach to treatment between all disciplines including the school staff. The attendance rate at school was 79%, a positive outlier for the area. We were informed by the headteacher that it was a combined effort by the team to increase attendance and get the young people excited and engaged with school. The young people received individual prizes for attendance and the wards received a prize for overall highest ward attendance.

The multidisciplinary team offices were based on the wards and it was evidenced throughout the inspection and from patient care records that the young people spent a large amount of time with different professionals and young people were actively engaged in activities and one to ones.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings; this was reflective of all professions working in a patient facing capacity including maintenance and domestic staff. We were informed that there was a key focus on consistency to avoid any “splitting” between the different disciplines involved in the young people’s care.

Ward teams had effective working relationships with other teams in the organisation. Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to the young people who used their services. They combined school and hospital initiatives to the needs of the patient group, such as a learning project surrounding sharing images of people following a series of safeguarding incidents on the wards, which led to significant improvements. The speech and language therapist had also attended school to teach the young people about interview techniques. Events were created to involve all staff across the multidisciplinary team and efforts were made to overlap the different aspects of patient care. For example, staff joined in on the young people’s themed fancy dress days (such as world book day) and available staff from all roles attended the Friday school quiz with the young people.

Ward teams had effective working relationships with external teams and organisations**.** They were inclusive and dynamic. They received excellent feedback from student nurse placements, as shared at the time of inspection, and had a high rate of students applying for permanent roles. The occupational therapy department had also arranged for Shetland ponies to go in to the school and had monthly exotic animal visits from local animal therapy groups.

Good

Child and adolescent mental health wards

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support. At the time of inspection one administrator was absent so the service was receiving on-site support from the regional lead.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. However, we were concerned that these processes and procedures were not always carried out in line with best practice. In the 12 care records we reviewed, all four of the young people who had had their detention under the Mental Health Act extended during the course of the pandemic had had the paperwork completed as per the Code of Practice, but had not received their hospital manager's hearings at the time of inspection; over 7 months after the renewal of one patient's Section. The provider informed us that this was due to delays that had occurred as a result of the pandemic as well as various technical difficulties. The hospital had sought guidance and had acted in line with advice received from the provider relating to requirements for hearing dates, but this was not in line with best practice. We notified the hospital of this following inspection and were informed that all applicable patients' manager's hearings had been booked.

Additionally, while staff had requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to; there had been an eight-day delay in requesting a SOAD for a change in patient medication for two of the four young people's paperwork we reviewed on Griffin ward.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. However, paperwork across the wards was not always consistent. The Section 17 leave forms had been amended to have a section to specify whether a risk assessment had been updated prior to leave being granted, this had not been completed in the records reviewed on Griffin ward.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The service had weekly access to male and female advocates to allow patients to speak with someone they would feel comfortable with. The advocacy service produced a report of their work with the young people that was discussed within local clinical governance meetings monthly.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Young people could also meet with the Mental Health Act administrators to discuss their rights and to prepare for tribunals. Staff had also produced a sensory bag to assist young people through tribunals, recognising that it could be a difficult process for them.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this, where applicable.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. However, these were carried out by the Mental Health Act office and we had concerns about the quality of some of the provider guidance they had been working in accordance with.

When a patient was placed in seclusion, staff did not always keep clear records and follow best practice guidelines. We reviewed four seclusion records; one patient's paperwork had not been completed in line with best practice for the use of seclusion as it was not clear when or why the seclusion had ended and did not document the independent multidisciplinary review within the form, though it had been documented in the young person's care records. This had also been identified during the hospital's audit of the record and lessons learned identified.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was cared for in long-term segregation, but evidence of this was not always easy to track. We reviewed a three-day period of one patient's long-term segregation record and associated care plans during inspection. The multi-disciplinary team and medical review sections had not been completed and stated to refer to another document. The food and fluid charts had also not been completed. As with the seclusion paperwork, the missing information could be found in other areas of the young person's care records. These errors had also been identified within quality audits and raised within the information governance meeting with lessons learnt and actions assigned to staff within the meeting.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There had been no Deprivation of Liberty Safeguards applications made in the 12 months prior to inspection.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. There was evidence within patient records that this had been applied appropriately to different decisions including involvement of family and receiving physical health care, and a best interest's meeting had taken place where appropriate.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Good

Child and adolescent mental health wards

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. Staff knew how to apply the Mental Capacity Act to patients 16 to 18 and where to get information and support on this.

Are Child and adolescent mental health wards caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff gave patients help, emotional support and advice when they needed it. Young people felt really cared for, that they mattered and valued their relationships with the staff team. Young people described the staff as “approachable, friendly and caring”; “lovely and kind” and that “it’s not just a job” to them. They told us that they were “amazing, they will help with anything and have helped me to cope better”.

Staff were discreet, respectful, and responsive when caring for patients. They spoke positively about their relationships with the regular staff but informed us that this was less consistent among the agency staff.

Staff supported patients to understand and manage their own care treatment or condition. During a patient’s care planning approach (CPA) that we observed, the consultant directed questions regarding care decisions and risk to the young person prior to involving the staff present; it was a collaborative process with the young person empowered to be at the centre of decision making. They were compassionate and complimentary and focused on strengths and achievements. A young person told us “they give you a lot of trust here” and “they work with you to find the best outcome for you”.

Staff directed patients to other services and supported them to access those services if they needed help. Young people told us they had been supported to access appointments and continue care outside of the hospital.

Patients said staff treated them well and behaved kindly. It was evident that the staff at all levels had worked to create secure relationships with the young people in their care, with boundaried but familiar interactions being observed throughout inspection. The multidisciplinary staff were observed to be warm and engaging with patients during groups. Young people in long-term segregation and on line of sight observations were observed to be playing games with the staff and there was a light-hearted atmosphere; even while on close observations young people told us “it’s nice here”. Senior managers were observed to have good knowledge of, and had sincere and funny interactions with, many of the young people during the inspection. During our interview with one manager, the young people were playing games with them from outside their office; and another manager had recently had 300 images of their face printed by the young people and placed all over the hospital to create a game for staff and young people.

Staff understood and respected the individual needs of each patient. Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff were open about examples of this and management were able to demonstrate where action had been taken in response to this.

Staff followed policy to keep patient information confidential. Patients informed us that staff "respect my dignity and privacy". However, two patients on Griffin ward informed us that staff did not always knock before entering their bedrooms and one anonymous comment card stated that some staff were "bad with confidentiality".

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. This process had recently been amended by the service to improve the young person's transition as well as to give a more accurate reflection of risk. Pegasus ward had started to contact the young person and their parents prior to admission to gain their perspective about risk, their care needs and whether this aligned with the hospital provision; they also gave them a welcome pack and introduction to the ward. These changes had been introduced following a period of higher acuity on the ward to give a greater oversight of risk and patient need than referral information could provide.

Staff supported patients to make decisions on their care. Staff found innovative ways to enable people to manage their own health and care when they can and to maintain independence as much as possible. Young people informed us that they felt involved and had been able to make decisions around their care, including medicine and risk management decisions, which was evident within the CPA observed during inspection. Care records were also extremely personalised and reflected their voices.

Staff involved patients and gave them access to their care planning and risk assessments. All patients spoken with had copy of their care records.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. They incorporated recovery into all elements of the young people's care while being mindful of their communication styles and individuality. For example, they recently held a competition to design a logo for the young people's council, the prize for which was two octopus soft toys that could be turned inside out to reflect whether you were in a positive or negative mood and provide a visual cue when people don't feel able to vocalise this. We were informed by a family member that the hospital had also created an image board to explain to their relative their change in diagnosis and how this may impact upon them.

Staff involved patients in decisions about the service, when appropriate. There were multiple, diverse examples of ways in which the young people had been able to impact upon service decisions. For example, a young person had asked for a prom in summer as they had bought their outfit prior to admission. The headteacher approached the CAMHS lead and it was agreed alongside a robust risk assessment involving the hospital's security lead. A marquee, limo, photographer and beautician service were called in and a prom dress and suit rental service donated clothes for the young people to use. The catering staff created a luxury menu and other staff took on roles such as DJs and doormen, all members of the multidisciplinary team attended.

The hospital also encouraged young people to have involvement about service decisions at provider level. Young people from the hospital had recently been involved in completing an environmental risk assessment of a new CAMHS hospital from within the Cygnet group to ensure the hospital was suitable for the patient group prior to opening.

Patients could give feedback on the service and their treatment and staff supported them to do this. There were comment boxes on the wards for young people to raise concerns anonymously, and the patients were involved in community meetings on the ward and contributed to a young people's council, this provided a forum to feedback and

request any changes to the service. Griffin ward had requested a real Christmas tree with string lights and decorations. This was risk assessed with the young people and a collaborative risk management plan was drawn up and the young people all used the decorations safely throughout the festive period. Another simple example was that a patient in long term segregation had requested to have a slow cooker in their area, so the hospital director ordered it the same day.

The hospital also held patient satisfaction surveys. In the most recent survey, 100% of respondents on all CAMHS wards stated that staff were caring and supportive always or sometimes; no responders stated that staff were not.

Staff made sure patients could access advocacy services. They had posters in communal areas and advocates visited the ward weekly (though this had been virtual during Covid-19 restrictions).

Involvement of families and carers

Staff supported, informed and involved families or carers. People who used services and those close to them were active partners in their care and staff were fully committed to working in partnership with people. Families were routinely invited to ward rounds and CPAs. Carers told us that their "opinions were respected" within these meetings. We were told that the hospital was "really receptive to my ideas, anything I suggest they will try" and that care was "very much a two-way conversation".

Staff told us that families would be approached before the meeting if difficult topics were going to be covered or to offer additional support before they came into the larger CPA forum. It had been identified that some parents felt more comfortable asking questions around school performance and education staff were present within these meetings to provide that familiarity and consistency.

Relationships between the young people who used the service, those close to them and the staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Carers were overwhelmingly positive regarding the care provided by the hospital. They stated that "staff were genuinely caring", "very patient-driven" and they "really couldn't fault it". Carers informed us that staff were also available to offer them support, stating that staff had told them "we're here for you as well" and they were able to phone the service whenever they required. They informed us that the communication had been really positive and they had always been informed about incidents, with some parents reporting regular additional communication with the ward managers. Carers told us that their needs were "definitely" considered by staff and "they really listen to us". Families had access to family therapy and were able to access this at a time to suit them.

Staff helped families to give feedback on the service and there was evidence of improvements having been made in response to this. For example, the hospital had recently introduced a lead family support role, this was a senior support worker post and they acted as the family liaison worker for the wards. Every Monday and Friday they called the families of the young people to update them and it provided the carers with a single point of contact. The provider had commissioned an external company to carry out a national evaluation of the role to detail what had worked well and consider any further opportunities for improvement.

Are Child and adolescent mental health wards responsive?

Good

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

Good

Child and adolescent mental health wards

Access and discharge

Managers did not always ensure bed occupancy did not go above 85%. However, this was routinely monitored, and the hospital was able to evidence times in which they put a hold on new admissions in response to periods of high acuity or to allow for stability following a change to the patient mix. Following a serious incident on one ward, the hospital had stopped all new admissions and had agreed with staff and the young people that no new patients would be introduced to the ward until the staff and young people agreed it was appropriate to do so.

The service had out-of-area placements. They informed us that young people would be placed close to family where possible but that they would prioritise patient safety. Staff worked collaboratively with commissioners and attended a CAMHS bed management group to regularly discuss bed vacancies nationally.

Managers regularly reviewed length of stay for patients and tried to ensure they did not stay longer than they needed to. However, the average length of stay for patients in the 12 months prior to inspection on Griffin ward was 313 days, Unicorn ward was 116 days, and Pegasus ward was 91 days.

Managers and staff worked to make sure they did not discharge patients before they were ready. Staff informed us that they tried to ensure that both the young person and the family were ready for this transition and would facilitate separate periods of extended leave to ensure that the family was prepared.

When patients went on leave there was always a bed available when they returned and no patients would be admitted into leave beds.

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. Following recent lessons learned, they were also trying to ensure that patients were discharged mid-week so that the multidisciplinary team was present to support.

The psychiatric intensive care unit could not always have a bed available if a patient needed more intensive care, or ensure that this was not far away from the patient's family and friends. The hospital informed us that they would try to accommodate this where possible, but they would prioritise admissions on a risk and suitability basis. There was also a limited number of CAMHS beds available nationally. This limitation informed many of the changes to the admission process on Pegasus ward and they had seen a decrease in acuity since that time.

Discharge and transfers of care

The service had 28 delayed discharges in the 12 months prior to inspection. One of these patients was delayed for three days while they awaited appropriate transport and all other delays were caused by difficulties accessing beds in appropriate follow on placements, this had impacted upon four internal transfers (three to Griffin ward and one to Unicorn while they awaited other delayed discharges), all others were external.

Managers monitored the number of delayed discharges. These were assessed regularly and discussed with community teams, commissioners and safeguarding where applicable.

The only reasons for delaying discharge from the service were clinical and due to the national shortage of CAMHS beds.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services. They were able to do phased discharges and the service remained contactable for both young people and their carers following discharge.

The service followed national standards for transfers.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom, which they could personalise. There was evidence across all three wards of young people having decorated their bedrooms. Young people spoken with were clear that they could do this and would be supported by staff to change the decoration. This extended into the ward areas, the young people had decided the colour schemes and been involved in creating murals on all of the wards; which were colourful, bright and featured a lot of LGBT positive images.

Patients had a secure place to store personal possessions. The hospital had also recently purchased new lockable storage, the young people had been involved in choosing these.

Staff used a full range of rooms and equipment to support treatment and care. Facilities and premises were innovative to meet the needs of a range of people who use the service. The wards had multiple communal areas and quiet spaces on each ward. Griffin ward also had a sensory room, with different lighting, scent boards and music; as designed by the young people. A new sensory room was being designed for Pegasus ward at the time of inspection. Unicorn ward had a cinema room and activity space.

The service had multiple quiet areas and a room where patients could meet with visitors in private; these were separate to the wards available for young people and included a small enclosed courtyard where young people could spend time with their pets and have picnics. One of the visiting areas was also used by the beautician and hairdresser who visited the hospital regularly to provide treatments to the young people.

Patients could make phone calls in private. All CAMHS wards allowed the young people to have access to smart phones, tablets and laptops and patients were individually risk assessed for their access to this. There was evidence within care records and safeguarding referrals of this being monitored and plans put in place as appropriate.

The service had a outside spaces that patients could access easily. These spaces had been muralled and were welcoming and inviting. The doors to outside areas were set to lock between specified hours; the timing of this was agreed with young people within community meetings and subject to regular review. Young people could still access the outside areas during the hours it was locked but would require staff supervision.

Patients could make their own hot drinks and snacks and were not dependent on staff. The wards had yoghurts, cereals, toast as well as fruit platters that were available after meals.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. Young people could access services and appointments in a way and at a time that suited them. Many of the groups, such as the art therapy group we observed during inspection, allowed young people to come in and leave at a time to suit them. The

hospital worked collaboratively, cohesively and supportively to achieve a consistent approach to patient care. Each ward had a dedicated member of education staff assigned who was part of the wards multidisciplinary team, attending handovers daily, CPAs and ward rounds. The head teacher also attended the information governance and the positive and safe meetings. School staff came onto the ward daily to provide individual teaching to patients who were unable to attend in person as a result of risk. The school also linked with the young people's community schools for specific courses to ensure continuity of education.

Staff helped patients to stay in contact with families and carers. We were informed by carers that young people had been supported to have home leave with a staff escort to maintain family links.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff assisted young people in the safe use of social media and the multidisciplinary team assisted in educating young people about appropriate relationships and used therapeutic interventions to support families.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for young people with multiple and complex needs. The hospital's speech and language therapist assessed their communication to ensure that it met accessibility standards, the reducing restrictive practice information was being assessed by them at the time of inspection. The occupational therapy team had produced flash cards with individuals to provide visual prompts to help them to express their needs quickly if English was not their first language or if they had limited verbal skills. The hospital had also introduced wristbands that could be turned over to state whether they were feeling positive or required support and the use of these was modelled by staff.

Staff made sure patients could access age appropriate information on treatment, local service, their rights and how to complain. All young people spoken with informed us that they felt informed and involved in their care and treatment and were confident to complain.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff gave a recent example of a patient who had entered the service who did not speak English; the service had used translation services, flashcards and had worked with the school to teach them English during their admission.

The service offered a variety of food to meet the dietary and cultural needs of individual patients. However, the young people spoken with during inspection did not speak positively about the food, saying it was poor and had a lot of carbohydrates; one patient said "there is only so much courgette you can eat" when discussing the vegan options available. This had been raised with the hospital through community meetings and the young people's council and the catering staff were working with the young people to improve the options available at the time of inspection.

Patients had access to spiritual, religious and cultural support. The hospital had different multi faith rooms available to patients, these had been decorated and had texts as requested by the young people. The hospital supported patients in practicing their faiths and recently supported a patient to visit the mosque weekly.

Good

Child and adolescent mental health wards

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. This included young people with protected characteristics under the Equality Act. Within the recent patient satisfaction survey, 100% of respondents from the CAMHS wards stated that the hospital supported diverse needs (spiritual, sexual orientation, ethnicity and race) "definitely" or "to some extent", no respondents said they did not.

The young people at Cygnet Hospital Sheffield had excellent LGBT support. The wards were colourfully decorated with multiple murals depicting the LGBT flag; preferred pronouns on the community meeting attendance sheets; and "Prom Royalty" was awarded in place of "Prom King and Queen" during the summer event to make the vote more inclusive. They held a range of LGBT celebration events, including trans day of visibility and held a pride party. Staff were mindful of preferred pronouns and care plans were reflective of this; staff modelled an open and inclusive attitude and approach.

Staff also worked with young people to provide appropriate support in line with their preferences. For example, senior multidisciplinary staff and ward staff that had been specified by the young person, attended court to support them through the difficult process. The same approach was applied to de-escalation and the use of restraint, ensuring the patient's safety was assured first. Staff told us that they felt a responsibility for building new associations for the young people, modelling healthy and secure attachments with males, for example, if patients did not have positive experiences of this previously.

Listening to and learning from concerns and complaints

Young people, relatives and carers knew how to complain or raise concerns. They were able to give examples of when they had done this and actions taken in response. For example, one young person had questioned the suitability of the service for patients with autism in a patient survey. In response the hospital had completed full environmental assessments of the wards and two staff members had completed working with young people with autism train the trainer courses, with training scheduled to be disseminated to the ward teams.

Young people's individual needs and preferences were central to the delivery of tailored services. The service clearly displayed information about how to raise a concern in patient areas and young people were able to raise concerns as one of the standing agenda items within community meetings. The young people's council provided the patients with a forum in which to raise their concerns and ideas for change. Young people told us that a lot of changes that had been brought about through these forums, including addressing night staff being noisy and changing patient debriefs.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. They were open and encouraging of feedback and viewed complaints as a learning opportunity. In the six months prior to inspection the service had received six complaints. Complaint information, responses and outcomes were discussed within the monthly local clinical governance meetings; there was an option to discuss themes but there were no themes among the complaints received.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Young people spoken with told us that they had felt safe to raise complaints with staff of all levels.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Good

Child and adolescent mental health wards

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. The hospital received a high number of compliments, they recorded 51 compliments within the four months prior to inspection and celebrated these, they were discussed as a multidisciplinary team within the monthly local clinical governance meetings. The staff offices had a lot of thank you cards and paintings from the young people and their families.

Are Child and adolescent mental health wards well-led?

Good

Our rating of well-led improved. We rated it as good because:

Leadership

Leaders were motivated, skilled and experienced, and performed their roles well. There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. They worked cohesively, were accomplished in their roles and well respected by the staff team, families and young people alike.

They were visible and available to both staff and patients who felt listened to. Leaders actively involved the young people and their opinions were at the forefront of service changes. Young people had even been involved in designing the appraisal and supervision tracker alongside the CAMHS lead.

Staff reported feeling supported and valued by their managers and received regular feedback. All staff spoke positively about the management within the hospital. They told us that they felt appreciated and respected by both ward and senior managers within the hospital.

Leaders could explain clearly how the teams were working to provide high quality care. There was strong collaboration, team-working and support across all functions within the hospital and a common focus on improving the quality and sustainability of care and people's experiences. They were proud of the improvements they had made to the service and were motivated to continue to improve the service provided to the young people in their care.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The values were on the computer home pages and in multiple areas around the hospital. The managers had also complied characteristics of care values with the human resources and marketing directors, these were included within recruitment information.

Culture

Staff felt proud of the work they did and the care they provided and spoke highly of the culture. Staff stated that although their jobs could be difficult, they enjoyed their roles and felt privileged to work amongst such a cohesive and supportive team and managers.

Good

Child and adolescent mental health wards

Staff felt respected, supported and valued by their colleagues and managers. In the recent hospital-wide staff survey 81% of respondents agreed or strongly agreed that there was a feeling of team spirit within their teams, 82% stated that their line manager treated them with respect, and 82% were happy with the support they received from their colleagues, no respondents strongly disagreed with this sentiment.

Staff had not reported any cases of staff bullying or harassment. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce and that the staff team remained representative of the young people using their service.

We queried the treatment of staff with a protected characteristic by staff and young people during inspection following a whistleblowing received. Within the recent hospital-wide staff survey, 7% of staff had reported that they had been subject to discrimination in the previous 12 months from either a colleague or young person. 2% of respondents said that they did not think that the provider recognised the challenges posed by staff with protected characteristics, 80% of respondents either agreed or strongly agreed that they did. In response to the survey, the hospital had evaluated the role of the bullying and harassment leads and increased awareness of freedom to speak up guardians and had introduced an on-site multicultural ambassador for staff to approach. The hospital also displayed information regarding the provider's Black and minority ethnic network and diversity and inclusion groups.

We were told by all staff that the staff team were respectful and supportive of one another and that the team contained a lot of people with protected characteristics, which was a celebrated aspect of care within the hospital. We were told that when a young person had been abusive as a result of one of these characteristics, it would be discussed openly within community meetings, mutual expectations reaffirmed and care plans would be updated; this was supported by the care records reviewed.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff informed us that they could comfortably approach their manager to inform them of errors, one gave the example that observations had been missed during an incident. We received eight whistleblowings or complaints in the 12 months prior to inspection, some of which related to the use of restraint and approach of staff. All were discussed with the provider and they were able to evidence lessons learnt and that appropriate actions had been taken in response to these concerns where applicable.

Staff felt confident to raise concerns with the registered manager and service lead. Staff at all levels were actively encouraged to speak up and raise concerns, and policies and procedures positively supported this process. All staff spoken with spoke very positively about the hospital director, clinical lead and CAMHS lead. They all said that they were caring, approachable and very visible on the ward. One staff member gave the example of the hospital director and clinical lead painting the courtyard on Unicorn with the patients, stating "you don't get many senior managers who would do that sort of thing".

Staff were aware of the whistle-blowing process and where to find the policy. Staff knew who the provider Freedom to Speak Up Guardian was and the hospital was training two new freedom to speak up guardians to act as local Guardians, internal to the service.

Staff appraisals included conversations about career development and how it could be supported.

Good

Child and adolescent mental health wards

Both the hospital and provider took part in staff awards. One of the consultants had recently achieved Cygnet's consultant of the year Star awards at a ceremony; a speciality doctor had also been short listed as a finalist. The wards also had a weekly award of "star of the week" for staff. The young people nominated the staff members during community meetings and submitted compliments. The staff member's name was then displayed, surrounded by the compliments and they were awarded a small trophy and a personalised chocolate bar.

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.

However, the information management systems in place were complicated and it could be difficult to identify specific information in some patient records. There were also concerns that the medicines management and Mental Health Act audits were not always effective at ensuring processes met with best practice. Other audits, such as the checks of care plans and restrictive intervention paperwork, were shown to have effectively highlighted the errors we had found during inspection and learning had been disseminated across the ward teams.

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what was discussed in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The service had robust recruitment processes in place. The strategy and supporting objectives and plans were innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. The hospital director had arranged sponsorship with a local sports team, resulting in Cygnet branding being present at matches and a regular slot within the brochure to advertise support worker positions. They also held open days and attended recruitment fairs at a local university. They provided supportive training for staff to pursue between three modules and a master's degree in fields associated with the service. The hospital also facilitated nursing apprenticeships, during which staff could maintain their current wage.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts. Managers and staff gave clear examples of changes that had been made. For example, new windows had been ordered for Pegasus ward following an incident that had occurred on the ward.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. The hospital had clear investigation procedures and were able to evidence instances where staff had been performance reviewed and disciplinary action taken where necessary.

They identified and escalated relevant risks and issues and identified actions to reduce their impact; though there were instances in which the timeliness of these changes had been delayed waiting for financial approval from a provider level.

The risk register was regularly reviewed and updated when necessary.

They had a clear business continuity plan to cope with unexpected events.

Staff contributed to decision-making and financial pressure did not compromise the quality of care. There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. The hospital director sat on the quality improvement steering group for the provider and the clinical manager was a quality improvement trainer. The hospital had increased their staffing numbers as part of a quality improvement framework. They were collating evidence to show the impact that this had had on patient experience and incidents to present to senior managers, with the aim to demonstrate improvements to ensure that the increased staffing levels were included automatically in future budgets.

Information management

The service collected reliable data and analysed it. Data was discussed as a multidisciplinary team within information governance, positive and safe and team meetings. Staff discussed the themes, compared it to data nationally and discussed improvement initiatives, as well as giving praise where improvements had been made.

The service did not always use systems to collect data from wards that were not over-burdensome for frontline staff. Staff could find the data they needed to understand performance, make decisions and improvements; but not always in an easily accessible format. For example, the physical health documentation was completed in various paper and electronic forms depending on the reason for recording, which made it difficult to track. The same was true of seclusion and long-term segregation documentation, it did not appear from the records that staff had been documenting food and fluid intake and had not accurately completed multidisciplinary and medical reviews or the time of seclusion ending in one instance; yet this information was all found within other areas of patient notes. The software that was used for handovers also reset the daily risk assessment to an automated risk, observation and leave status; staff had to remember to amend this whenever it was opened to ensure it was accurate, this had resulted in one young person showing as the incorrect observation level at the time of inspection.

The registered manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. They were part of multiple groups within the provider structure and locality to assist with shared learning, benchmarking and communication.

Staff made notifications to external bodies as needed including the CQC, commissioners and the local safeguarding team. They had done a lot of work to engage external community teams. There was a demonstrated commitment at all levels to sharing information proactively to drive and support internal decision making as well as system-wide working and improvement. They encouraged external oversight and had sought inspection and feedback from external stakeholders.

Staff had access to the equipment and information technology needed to do their work.

Engagement

Good

Child and adolescent mental health wards

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The hospital website was updated frequently and families were given regular verbal updates, and would receive emailed updates if they had not been able to attend meetings; this included written updates to parents and carers if they had been unable to attend CPAs.

The registered manager actively engaged in the network for the local provider collaborative. The service had frequent contact and a strong working relationship with NHS England and commissioning teams. The CAMHS lead had also introduced young people to the interview panels.

Managers from the service participated actively in the work of the local transforming care partnership. They arranged care and treatment reviews when relevant.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

The young people's council had also been expanded to include quarterly meetings with councils across other Cygnet CAMHS services in the North.

Innovations were taking place in the service. Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. The hospital had a clear focus on innovation and improvement within the service and actively involved the young people in these initiatives; with the work progressing through the reducing restrictive practice lead being an excellent example of this.

The hospital utilised staff and patient surveys to improve hospital conditions and treatment practices. Following the recent hospital-wide staff survey, it had been identified that the initiatives that had been planned to improve staff break rooms had been pushed back in favour of on-ward improvements. At the time of inspection work was commencing to create new break spaces for staff.

Staff participated in national audits relevant to the service and learned from them. They submitted data for national benchmarking in areas such as restrictive practice to inform internal targets on the wards.

The wards took part in nationally recognised accreditation schemes. They were participating in the Quality network for inpatient CAMHS; two wards had been positively peer reviewed in December 2020 and they were expecting to have their formal accreditation review shortly after inspection. Unicorn ward had also been the first psychiatric intensive care unit in the country to achieve CAMHeleon accreditation, a model designed by Star Wards, Griffin and Pegasus were working to embed this model across their wards too.

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

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

Safe and clean care environments

The ward was clean, well equipped, well furnished, and maintained. There were several environmental issues identified on the hospitals risk register.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The most recent fire risk assessment in April 2021 had identified a potential fire risk with cladding on the building, which had previously been identified in 2018. Following the 2021 report, the provider arranged a specialist survey in August 2021 that concluded the building construction did not pose a risk regarding fire safety.

Staff could not observe patients in all parts of the wards due to the ward layout. However, staff used regular observations in line with patients' risk assessments to reduce the risks. Closed-circuit television was available in communal areas including lounges and corridors. Patient bedroom and bathroom doors were designed to prevent holding, barring or blocking.

There was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The ward had an up to date ligature risk assessment, and a ligature awareness pack for staff provided photos of where ligatures could be fastened to anchor points within the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were regularly checked, and action taken when issues were identified. We saw staff responding quickly to alarm calls during the inspection.

Maintenance, cleanliness and infection control

Good

Forensic inpatient or secure wards

Ward areas were clean, maintained, and well-furnished. There was an onsite maintenance team and a system for reporting maintenance work in a timely manner. The ward was due to be re-painted in November 2021.

At the time of inspection, there were several environmental issues related to Spencer ward on the hospital risk register. The en-suite bathroom doors were due to be replaced. This had been on the risk register since October 2018, these were adapted in May 2019 but there continued to be an associated risk. We were informed that these had been raised as a request to the provider but due to the low ligature risk of the patient group (the ward had two ligature incidents within the 12-month period leading to inspection), replacement of the doors was not approved until March 2021, for completion in the final quarter of 2021. These arrived the second week of inspection but had not been fitted. The hospital manager explained that following consultation with the patients on Spencer Ward, it was planned that these would be replaced as patients were discharged.

The seclusion suite had been identified as not being fit for purpose and placed on the risk register in June 2020. The planned upgrade to install a shower was due to be completed in 2022. Some remedial work had been carried out in the interim to improve temperature control within the room.

Spencer ward was on the first floor of the hospital and the lift had been out of order since 9 July 2021. Most nurses, support workers and two patients we spoke to identified the lift being broken as a concern. Staff had to carry food and provisions in large polystyrene boxes up and down two flights of stairs three times a day. There was a moving and handling risk assessment in place and hospital senior managers had explored alternatives such as the patients eating in a large meeting room on the ground floor of the hospital. This had been declined by the patients on Spencer ward. There was evidence of the hospital attempting to resolve the concern, but this process had been delayed awaiting expenditure approval at provider level.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff followed safe working practices. Patients and carers told us the environment was clean.

Staff followed infection control policy, including handwashing. Receptionists at all the entrances to the hospital ensured staff and visitors followed COVID related infection control protocols.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock that was visible from inside the room. There was a potential ligature anchor point within the seclusion room. Staff were aware of this and seclusion care plans detailed how staff would manage this if this was identified as a risk for the patient.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff recorded daily room temperatures and fridge temperatures and knew actions to take if these were out of range. Medicines were stored appropriately and did not exceed expiry date.

Resuscitation equipment was stored in the ward office. This was checked daily by nurses and all equipment was in order. Emergency medicines were available and checked regularly.

Staff checked, maintained, and cleaned equipment. Nurses had access to equipment for monitoring physical observations which was regularly clean and maintained.

Good

Forensic inpatient or secure wards

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.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

Staffing levels were planned to be two registered nurses and five support workers during the day, and one registered nurse and four support workers during the night. Additional staff were brought in if there were additional observations to complete. Staffing levels were reviewed each weekday morning during a site-wide situation report meeting. We reviewed rotas and situation report data for June – September 2021. Most shifts met the required staffing levels.

Nurses and the manager reported that staff tried to do a lot with the patients, for example facilitating a large amount of section 17 leave. The manager had recently introduced an extra member of staff to work during the day to support patient leave and ensure that an additional nurse was available when multidisciplinary team meetings occurred. This was in response to some staff and patients reporting that there were times when there were not enough staff, these strategies had not been fully embedded at the time of inspection.

The service had low and reducing vacancy rates. They had more nurses and support workers in post than necessary to meet their minimum staffing levels. The service aimed to recruit more staff so that they could reduce the use of bank and agency staff further.

The service rarely used bank or agency nurses.

The service used bank and agency support workers to undertake observations. The proportion of bank and agency staff were reviewed in the situation report meeting each weekday morning.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The rotas we reviewed showed bank and agency staff worked regularly at the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included completing an observation competency assessment. Regular bank and agency staff also received clinical supervision.

The hospital had reducing turnover rates. The turnover rate was 42% across the hospital, a 46% reduction from the previous year. 32.5% of the turnover rate was due to bank staff not picking up shifts and their contract being terminated. Of the permanent staff leaving, only five out of 82 staff worked on Spencer ward.

Managers supported staff who needed time off for ill health. The provider had an employee assistance scheme that was advertised in the staff office.

Levels of sickness across the organisation was 7.54%.

Managers accurately calculated and reviewed the number and grade of nurses, and support workers for each shift.

Good

Forensic inpatient or secure wards

The ward manager could adjust staffing levels according to the needs of the patients. Additional staff could be requested if there were more patients on observations, or higher levels of observations than assumed within the core staffing. This was reviewed in a daily situation report meeting with ward managers and senior leaders within the hospital.

Patients had regular one to one sessions with their named nurse. Patients told us these happened regularly.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff encouraged patients to take unescorted leave where possible. The service had employed an activities coordinator to facilitate more activities five days a week.

The service had enough staff on each shift to carry out any physical interventions safely. All staff were trained to carry out physical interventions safely, and they could call for assistance from staff on other wards if necessary.

Staff shared key information to keep patients safe when handing over their care to others. We observed a handover and a morning meeting on the ward during the inspection. These were comprehensive, person-centred and shared lessons learnt from the previous shift. Care records were detailed with up-to-date information.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers did not use locum doctors. The Spencer ward consultant and specialty doctor were permanent employees.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Overall training compliance was 98.4% on Spencer ward.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training covered a broad range of key skills. This included relational security and was supported by See, Think, Act 2nd Edition.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff could complete online training at home or at the hospital site and were paid for their time. Managers also arranged refresher training for staff when necessary.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. 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 effective strategies 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.

Assessment of patient risk

Good

Forensic inpatient or secure wards

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed six patient records. All patients had risk assessments that were comprehensive and up to date.

Staff used two recognised risk assessment tools which risk considered risk of violence to others, suicide, self-harm, self-neglect, substance misuse, unauthorised leave and victimisation. Case specific risk areas including offending behaviour were also considered.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Each patient had a positive behaviour support plan that included details about what the patient and staff could do to support them when they were distressed. All the plans we reviewed included individualised risk management strategies, graded according to the level of risk the patient was demonstrating.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff completed a daily risk assessment for each patient in their electronic care record. This identified current risks, observation levels, any individual restrictions, incidents patients had been involved in and information related to engagement. We observed a morning meeting and saw multidisciplinary team members discussing areas of risk and making changes to a patient's care plan.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff used regular observations in line with patients' risk assessments to reduce risks and reviewed these observation levels regularly to reduce them when safe to do so.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. Between 1 September 2020 and 31 August 2021 there were 129 incidents of restraint on Spencer ward. There were no incidents of prone restraint.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Based on this work, the ward had employed an activity coordinator to provide activities in the evenings and at weekends when patients were more likely to feel distressed. The patients had also designed a sensory room. The equipment for this was due to be installed following inspection.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Incident reports detailed the efforts staff had made to verbally de-escalate situations prior to using physical interventions. During the inspection we saw staff deal with situations calmly and demonstrating good de-escalation skills.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. Between 1 September 2020 and 31 August 2021, rapid tranquilisation was used on 41 occasions. This included both oral and rapid tranquilisation given by injection. Patients had detailed rapid tranquilisation care plans that identified their preferences and outlined which medications to use first. Physical health monitoring was completed, and managers audited this every month.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There were seven episodes of seclusion between 1 September 2020 and 31 August 2021. We reviewed records from two episodes of seclusion. The documentation was well completed, and seclusion care plans included patient preferences and views. The manager reviewed every incident of seclusion to ensure it was justified. There was evidence within local governance meeting minutes that on one occasion when seclusion had not been justified, the service issued a full apology to the patient and supported staff with additional training and supervision.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There had been no episodes of long-term segregation between 1 September 2020 and 31 August 2021. However, one patient was in long term segregation on the ward at the time of inspection. The ward had no extra care area and the patient was using their bedroom. The patient could access a quiet lounge area on the ward, close to their bedroom. The patient's care plan stated access needed to be when other patients were not using it. However, the ward manager noted that other patients rarely used this lounge area and the patient in long-term segregation had always been able to access the lounge when they wanted to. The patient also had access to fresh air in the ward courtyard, used by other patients. The patient had a care plan in place and reviews and observations were fully documented.

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.

Staff received training on how to recognise and report abuse, appropriate for their role. The hospital manager, clinical manager and lead social worker completed Level 4 safeguarding training. All other staff completed Level 3 training.

All staff were kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The senior social worker and clinical manager were safeguarding leads within the hospital. Their details and pictures were displayed on the ward.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service engaged with the local safeguarding boards, and supported patients to liaise with the police when needed.

Staff followed clear procedures to keep children visiting safe. Children did not come onto the ward. There was a visitor's room on the ground floor of the hospital that patients could use. The hospital had a clear protocol in place to prevent adults and young people meeting when young people were moving from Pegasus ward to the onsite school.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Social work staff completed a debrief with any patients involved in a safeguarding incident. These were recorded in care records which were clear and detailed, and reviewed in multidisciplinary team meetings.

Good

Forensic inpatient or secure wards

Managers took part in serious case reviews and made changes based on the outcomes. There had been no serious case reviews related to Spencer ward. However, the service had requested an external case review following a number of allegations being made about staff conduct by one of the patients on the ward.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The incident reporting system was linked to the patient's care record so staff could easily see if the patient had been involved in any incidents.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. There were processes in place to ensure that paper records, such as seclusion documentation, were scanned onto the computer and stored in an organised way.

Records were stored securely. Staff, including agency staff, had their own log in to the computer system.

Medicines management

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

We reviewed five prescription charts. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The provider had a contract with a registered pharmacy who delivered medicines for all patients in the hospital and provided a clinical pharmacist who visited the service each week. Medicines were stored securely and were only accessible to authorised people. There were arrangements for the management of controlled drugs.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw evidence of medicines discussions in patient records and capacity documents were well completed.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The provider had clear medicines policies in place that were easily accessible to staff.

Staff followed current national practice to check patients had the correct medicines. Staff completed medicines reconciliation when patients were admitted.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Incidents were reported and action taken to disseminate learning, for example clear documentation.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines were regularly reviewed, including as needed medicines. The pharmacist also completed a weekly prescription review and stock check, highlighting any areas in a report for managers to action.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Care plans detailed the possible side effects of medication and physical health monitoring was completed by the physical health care team.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised most 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.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported most incidents in line with provider policy.

The service had not reported any serious incidents or never events between 1st October 2020 and 23rd September 2021.

Managers debriefed and supported staff after any serious incident. Most staff told us about different types of debrief they had after incidents. These included informal debriefs in the ward office after an incident. These occurred either individually or as a group. Formal debriefs were documented with a senior member of staff for example if a member of staff had been assaulted. Staff could also attend a weekly reflective practice group on the ward. However, the recording of debriefs was inconsistent and some support workers told us they did not receive debriefs after incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence of the investigations and duty of candour letters provided by the manager to patients when things had gone wrong. Staff received additional supervision and training.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff discussed incidents, including themes and trends, within staff meetings. Managers circulated 'red top' alerts which contained feedback from incidents that had happened in other services.

There was evidence that changes had been made as a result of feedback, for example changes to local audits and checks.

Managers shared learning with their staff about never events that happened elsewhere.

Good

Forensic inpatient or secure wards

Are Forensic inpatient or secure wards effective?

Good

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

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.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Assessments were holistic, personalised and include physical health care check.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The hospital had a physical health team comprising of two support workers. Each patient had a physical health monitoring record that outlined what monitoring was required. The team managed blood tests and observations which were regularly required for patients taking antipsychotic medicines.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed six care records and all were detailed, personalised, holistic and recovery-orientated. Care plans reflected patients' preferences and goals and every care plan included the patient's views. However, they were not always reflective of the work being undertaken towards discharge planning.

Staff regularly reviewed and updated care plans when patients' needs changed. The multidisciplinary team met every weekday morning and quickly made changes to care plans when patients' needs changed.

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.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. Spencer ward were piloting a new model of care based on a four-stage recovery focused pathway. This pathway was based on principles of least restrictive practice, coproduction and trauma informed care. Patients had access to occupational therapy and psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE). These included cognitive behaviour therapy, art therapy and trauma informed approaches.

Patients were provided with a minimum of 25 hours of meaningful activity each week. Patients had personalised activity timetables so that they were aware of when their sessions were taking place. The level of their engagement was audited monthly and included in the ward's data pack.

Good

Forensic inpatient or secure wards

Staff identified patients' physical health needs and recorded them in their care plans. Physical health audits were completed every six months. Staff had addressed shortfalls in previous audits and had scored 89% compliance in the most recent audit.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The occupational therapist and doctor ran a regular programme of events about healthier lifestyles, which included advice about healthy eating and exercise. The service also had a fitness instructor who supported patients to develop a personalised fitness programme.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Health of the Nation Outcome Scales to monitor patient outcomes.

Staff used technology to support patients. Patients had access to three computers on the ward and the ward had ordered tablets to make access easier so patients could engage in educational courses for example. Family members joined multidisciplinary team meetings via video calls.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff completed several monthly audits to review patient records, rapid tranquilisation, observations and infection control. They also completed additional audits on a quarterly or annual basis such as audits around physical health care, Mental Health Act and blanket restrictions.

Managers used results from audits to make improvements. Results from audits were included in the monthly data pack, received by managers. Staff discussed the outcomes of audits within the staff meetings and each audit had an associated action plan.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. 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.

The service had a full range of specialists to meet the needs of the patients on the ward. The multidisciplinary team included appropriately trained medical staff including forensic psychiatrists, a clinical psychologist, mental health nursing staff, occupational therapy and social worker staff supported by other therapists including an art therapist. The patients and staff spoke highly of the multidisciplinary team, with patients commenting the team were skilled, consistent and fair.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff developed one-page profiles with patients to ensure all staff had the right knowledge to support them effectively.

Good

Forensic inpatient or secure wards

Managers gave each new member of staff a full induction to the service before they started work. Staff received five days off site mandatory training before they joined the service. A comprehensive induction booklet had been developed to improve the experience of new staff which was completed alongside a more experienced staff member. All staff completed an observations competency assessment before starting work on the ward.

Managers supported staff through regular, constructive appraisals of their work. This included permanent medical and non-medical staff. The appraisal rate was 100% at the time of inspection.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work. The supervision rate was 96% at the time of inspection.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed the minutes of the last three staff meetings. There was a clear agenda and issues were followed up between meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The provider had a nursing transition route for support workers who wanted to train to be registered nurses. The manager encouraged staff to identify areas of development within supervision, for example participating in audits. However, one support worker felt there was a lack of development opportunities.

Managers made sure staff received any specialist training for their role. This included training about relational security and trauma risk management. The ward manager had also been nominated by the provider collaborative to complete an autistic spectrum disorder train the trainer course to enable them to provide training for the region.

Managers recognised poor performance, could identify the reasons and dealt with these. The ward manager gave clear examples of the process followed to deal with poor performance and how this had been used in the previous 12 months. This included providing additional training and support.

The service did not use any volunteers. However, the occupational therapist sourced sessional staff who visited the hospital to provide other activities and interventions for patients such as a beautician, and a variety of animal-assisted therapies.

Multi-disciplinary and interagency 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 team 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 held regular multidisciplinary meetings to discuss patients and improve their care and included patients, their carers and other professionals. Staff said all team members had a voice in the meetings and could challenge each other effectively. We observed one multidisciplinary team meeting and saw this to be the case. The meeting covered detailed, holistic discussion of the patients care.

Good

Forensic inpatient or secure wards

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed a handover, a morning meeting and a daily situation report meeting. Each meeting had a clear structure that ensured clear information was communicated between staff and that the daily risk assessment recorded the most up to date information.

Ward teams had effective working relationships with other teams in the organisation. The ward was the only adult service in the hospital. However, the staff and the manager worked effectively with other teams and within the hospital wide governance structure, for example working to support with incident response on other wards.

Ward teams had effective working relationships with external teams and organisations. The service was involved in the Yorkshire and Humber Involvement Network and had strong links with a range of external organisations and the community forensic team. This meant that patients were supported to access community opportunities and when being discharged.

Adherence to the Mental Health Act and the Mental Health Act 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.

Staff received, and kept up-to-date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Mental Health Act training compliance was 100% on 30 September 2021.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There were Mental Health Act administrators on site and staff knew who they were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Policies were easily available on the providers policy library.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Posters were displayed on the ward advertising advocacy services and the advocates visited the ward twice a week.

All patients were detained under the Mental Health Act. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's records each time. Staff checked in community meetings if patients wanted their rights explained again.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients used their leave to do a wide variety of activities in the community including exercise, attending church, and to spend time with their relatives.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw copies of up-to-date T3 certificates stored with medicine charts. These are certificates completed by a second opinion appointed doctor to authorise treatment under the Mental Health Act if a patient cannot consent or refuses treatment which is necessary for mental illness.

Good

Forensic inpatient or secure wards

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans did not always reflect the work staff were doing with the patients towards their discharge, including information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Staff worked effectively and liaised with local area services and the community forensic team to facilitate discharge and ensure that after-care services were available for those patients who were eligible.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The most recent audit in June 2021 identified several actions. These had been completed at the time of inspection.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up-to-date with, training in the Mental Capacity Act and had a good understanding of at least the five principles. Mental Capacity Act training compliance was 100% on 30 September 2021.

There were no deprivations of liberty safeguards applications made in the last 12 months. All patients were detained under the Mental Health Act.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Policies were easily available in the provider's policy library.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff would approach the registered manager, clinical manager or senior clinicians on the ward with any queries.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Best interests' decision were made after consulting a range of people, including the patient's family and advocate when appropriate.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples of capacity assessments related to individual restrictions that were in place for some patients, such as access to their mobile phone. However, the capacity documentation was not always completed accurately, there were omissions in one form and incorrect boxes had been selected on another.

The service did not monitor how well it followed the Mental Capacity Act. However, the provider audited how staff applied the Mental Capacity Act quarterly. Staff identified and acted when they needed to make changes to improve. The most recent Mental Capacity Act audit showed poor compliance on Spencer ward as staff had not used the required documentation. Action had been taken at the time of inspection to address this.

Are Forensic inpatient or secure wards caring?

Good

Forensic inpatient or secure wards

Good

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

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.

We spoke with seven patients and three family members. Feedback about the staff was positive, with carers describing staff as lovely, professional and polite.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff speaking gently with patients in distress. Staff were respectful when speaking to other staff in meetings about patients and their care.

Staff gave patients help, emotional support and advice when they needed it. Positive behaviour support plans detailed types of emotional support and help patients wanted when distressed. Staff had worked with patients to produce one-page profiles so that new staff could get to know them quickly.

Staff supported patients to understand and manage their own care treatment or condition. Patients we spoke to understood their care and treatment. Patients on the ward produced a newsletter which showcased their achievements, and shared poetry, recipes and recent events such as the charity fun run.

Staff directed patients to other services and supported them to access those services if they needed help. Patients who were close to discharge were involved in a wide range of community services and activities, which staff helped them to access when necessary.

Patients said staff treated them well and behaved kindly. Patients described feeling well cared for and that it was "the little things" staff did that made a difference.

Staff understood and respected the individual needs of each patient. Staff were consistent in the use of patients' preferred pronouns. One patient described how "staff want to work with you" and emphasised a least restrictive approach.

All staff felt confident that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients or between patients.

Staff followed policy to keep patient information confidential. Staff only shared information with a patient's family when the patient had consented.

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.

Good

Forensic inpatient or secure wards

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us staff showed them around the ward when they first arrived, although during the COVID-19 pandemic, this was delayed due to needing to isolate initially.

Staff involved patients and gave them access to their care planning and risk assessments. Care plans captured their views and preferences.

Staff made sure patients understood their care and treatment. They were involved in creating personalised care plans and in multidisciplinary team meetings.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held on the ward fortnightly. The service also ran a people's council and a positive and safe group. Through these groups the service had introduced an activity organiser role and were developing a sensory room on the ward.

No patients had made advanced decisions on their care. However, patient preferences and views were evident in all their care plans. Each patient's positive behaviour support plans included very individualised strategies to help them manage when they were distressed.

Staff made sure patients could access advocacy services. The advocates visited the ward regularly and attended meetings with patients. Patients spoke highly of their advocates.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Family members we spoke with told us they were involved in the care and their opinions were respected and listened to. With consent, the lead support worker provided regular updates to families based on their preference. Prior to the COVID-19 pandemic, the service arranged carers' days so families and carers could visit the service. They ensured there were extra staff available to spend time with patients who did not have contact with their families.

Staff helped families to give feedback on the service. The service used a range of ways to get feedback from carers. Most commonly this was during multidisciplinary team meetings, which families attended regularly.

Staff supported patients to maintain healthy carer and family relationships. Family members told us that staff were considerate of their limits and supportive.

Family members told us staff had not given them information on how to find a carer's assessment. However, one family member commented "I'm not a carer". Social work staff told us they provided information to families about support services in their area, where this had been passed on by local community teams.

Are Forensic inpatient or secure wards responsive?

Good

Forensic inpatient or secure wards

Good

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

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.

Bed management

Between 1 September 2020 and 31 August 2021, bed occupancy was 96.7%. Staff carefully planned admissions and discharges. Waiting times for the service were not excessive.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The service had discharged five patients in the previous six months and several other patients were actively working towards discharge at the time of inspection.

The service had low out-of-area placements. Most patients were from South Yorkshire.

Managers and staff worked to make sure they did not discharge patients before they were ready. Staff identified and addressed the immediate needs and concerns for patients in relation to their transition to other services or to the community.

When patients went on leave there was always a bed available when they returned.

Patients were not moved to other wards at Cygnet Hospital Sheffield because the other wards were for children and young people. Patients who had recently been discharged had moved to rehabilitation placements with lower levels of security or discharged to their own home.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had reducing numbers of delayed discharges in the past year. Managers monitored the number of delayed discharges. At the time of inspection, two patients were delayed in their discharges. Both were awaiting accommodation.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff worked effectively and liaised with local area services and the community forensic team to facilitate discharge. The community forensic team attended multidisciplinary team meetings and several patients were on the discharge pathway. However, one relative raised concern that they had not been involved in the initial discussions about discharge or meeting with the community team. In addition, the level of work being undertaken with patients was not always reflected in their care plans.

Good

Forensic inpatient or secure wards

Staff supported patients when they were referred or transferred between services. Discharges were carefully planned with patients having the opportunity to stay at a new placement before being discharged.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make hot drinks and snacks at any time. However, there was mixed feedback about the quality of the food.

Each patient had their own bedroom, which they could personalise. Patients had decorated their room with pictures and photos.

Patients had a secure place to store personal possessions. Patients had a locker in their room and could store larger items in a restricted cupboard in their bedroom. The bedroom corridor was decorated with murals the patients had created, including a LGBT+ teapot.

The service had a full range of rooms and equipment to support treatment and care. The service was developing a sensory room on the ward which had been designed by patients. Some rooms were open, whilst other rooms were locked, such as the activity room. Patients were individually risk assessed for either independent or escorted access to this room due to some risk items within the area. A large meeting room was being converted into a cinema room with a projector which could also be used for multidisciplinary team meetings

The service had quiet areas and a room where patients could meet with visitors in private. The visitor's room was off the ward.

Patients could make phone calls in private. Patients had access to their own phone, unless this was restricted based on an individualised risk assessment or capacity assessment.

The service had an outside space that patients could access easily. Access to the courtyard was from the main lounge area and patients were growing flowers and vegetables in containers.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients had food lockers in the dining room where they could store their own snack foods.

Some staff and patients reported that the food did not meet the needs of the patients on Spencer ward. The menus were discussed in the hospital's governance meeting in August 2021, with the minutes noting that although kitchen staff were kind and responsive when attending community meetings on the ward, this had not resulted in changes to the menu. Actions were identified following this meeting including revisiting a programme that had previously been trialled on Spencer ward where patients could "build" a meal by choosing different elements, rather than choosing a pre-defined meal.

Patients' engagement with the wider community

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

Good

Forensic inpatient or secure wards

Staff made sure patients had access to opportunities for education and work, and supported patients. There were opportunities for patients to apply for paid therapeutic work roles within the hospital. Patients were supported to get voluntary work within the local community, for example at a local farm, or in charity shops. Patients could access online learning and the service were in the process of getting tutors from the local college to support patients with English and maths.

Staff helped patients to stay in contact with families and carers. Several patients used their section 17 leave to visit or stay with their families.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff supported patients to participate in activities outside of the unit. 10 of the patients had recently participated in a charity fun run with staff. Some patients accessed exercise opportunities in the local community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. For example, staff adapted recipes and timetables to include pictures when necessary. Where patients needed additional support to communicate, such as via a hearing aid, staff supported this. However, one patient told us that staff did not always use their communication strategies effectively.

Wards supported disabled patients. The occupational therapist completed assessments when patients required aids or adaptive equipment such as shower chairs. We saw these in place during the inspection. However, at the time of inspection the lift was broken, and two patients raised concerns about using the stairs with mobility concerns.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff arranged interpreters for patient's meetings when their family did not speak English.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Vegetarian options were available. When a patient with diabetes had a birthday, kitchen staff provided an alternative to cake, for example strawberries and cream.

Patients had access to spiritual, religious and cultural support. The hospital had a multi-faith room available for patients, and an area of the quiet lounge on the ward was being developed as a spiritual space. Some patients accessed spiritual support either online or through attending local churches.

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.

Good

Forensic inpatient or secure wards

Patients, relatives and carers knew how to complain or raise concerns. They felt confident to do so and that staff would listen to them and be responsive.

The service clearly displayed information about how to raise a concern in patient areas. There were complaints leaflets available and information displayed about other ways to raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. We reviewed four complaint investigations. These were detailed and addressed the concerns raised.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The final response complainants received provided detail about what to do if they were not happy with the result.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed as part of staff meetings and the meeting minutes shared. There were few complaints from patients on Spencer ward.

The service used compliments to learn, celebrate success and improve the quality of care. However, the compliments log did not reflect all the compliments received. We saw compliments documented in staff meeting minutes, community meetings, in cards from clients and comments had been made by a range of staff and patients about the recent charity fun run that had not been documented.

Are Forensic inpatient or secure wards well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

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 were approachable for patients and most staff.

Leaders were motivated, skilled and experienced, and performed their roles well. They were visible and available to both staff and patients. The senior managers within the hospital visited the ward regularly and the clinical manager participated in a range of activities with patients including the recent charity fun run and karaoke. Nurses and clinicians reported feeling supported and listened to by the senior managers. However, support workers reported that they did not feel the senior managers were visible in the service other than to complete spot checks.

Staff reported feeling supported and valued by their manager and received regular feedback. Staff spoke highly of the ward manager and felt very supported by them. However, support workers we spoke to did not feel valued by the senior managers within the hospital.

Good

Forensic inpatient or secure wards

Leaders could explain clearly how the teams were working to provide high quality care.

Vision and strategy

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

The values were displayed on posters and on the desktops of computers. We saw staff consistently acting in line with the values; and patients and carers described staff as respectful, caring, and working to empower patients in their recovery.

Culture

Staff felt respected, supported and valued by their immediate team. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. Most staff said they could raise any concerns without fear.

Staff felt proud of the work they did and the care they provided. Staff felt respected, supported and valued by their colleagues and the ward manager. Staff had not reported any cases of staff bullying or harassment. However, some staff did not feel valued by the senior managers or wider organisation.

The service had an open culture where patients, their families and staff could raise concerns. However, when staff had raised concerns regarding the lift being broken, ward-based staff were prevented from having hot meals while at work. Several staff experienced this as a punishing response. This had been changed at the time of inspection and staff could choose to eat hot or cold meals whilst working.

Nurses and multidisciplinary team members felt confident to raise concerns with the registered manager and service lead. However, the mental health support workers we spoke with did not feel confident to raise concerns with the senior leaders in the hospital, fearing their concerns would be dismissed. This was particularly around concerns regarding pay, and the lift being broken.

Staff were aware of the whistle-blowing process and where to find the policy. Staff did not know who the Freedom to Speak Up Guardian was.

Staff appraisals included conversations about career development and how it could be supported. Staff could put in a training request application to support continuing professional development. However, some support workers felt progression opportunities were limited.

The ward presented a star of the month award to a staff member nominated by patients.

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.

However, there were errors or omissions identified within some forms of documentation on the ward. Incident reporting was not always consistent as there were omissions in the recording of debriefs. Discharge care plans were not always reflective of the work undertaken to support the patients. There were errors within Mental Capacity Act assessments, though audits had identified concerns relating to the ward's compliance with best practice and had identified actions to address this.

Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what was discussed in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The service had robust recruitment processes in place. The registered manager was able to run a data integrity report to ensure that all staff had the required paperwork in place including DBS checks, nursing registration and right to work documentation.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts. Managers and staff gave clear examples of changes that had been made.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care. However, timely action was not always taken to mitigate risks identified.

Leaders and teams used systems to manage performance effectively within the hospital. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The risk register was regularly reviewed and updated when necessary. However, although risks had been placed on the risk register and promptly escalated by the hospital managers, action was not always taken by the provider in a timely way.

- A potential fire risk of cladding on the building had been identified in 2018 and a specialist survey was not carried out until August 2021. This survey identified that the cladding was not actually a risk.
- The en-suite bathroom doors had been on the risk register since October 2018. The new en-suite doors were delivered from a partnership hospital during the second week of inspection and were planned to be replaced as patients were discharged. Five patients were discharged in the six months prior to inspection and the en-suite doors had not been replaced in these rooms.
- The seclusion room was identified as not being fit for purpose in June 2020. Although some remedial work had been completed, the planned upgrade to install a shower was due to be completed in 2022. At the time of inspection, the plans had not been drawn up.
- The lift to Spencer ward was reported broken and out of use on 9 July 2021 and was put on the hospital risk register on 2 August 2021. Following the inspection, the provider gave a narrative regarding the approach taken to carry out the required lift repairs at Cygnet Hospital Sheffield. This provided a timeline for different aspects of the process which included liaising with contractors. This identified that the approval from the provider for the specialist required parts to be ordered from overseas was made on 13 September 2021 following both the due diligence and expenditure approval process being complete. The provider identified this process took 47 working days from the time the lift was reported broken; this did not reflect that the lift had been broken for 67 days.

The service had plans to cope with unexpected events, which included details and contact information for senior managers, utility services, emergency services, commissioners, staffing agencies and insurance.

Information management

Staff collected, analysed data about outcomes and performance, and engaged actively in local quality improvement activities. Staff had access to the equipment and information technology they needed to do their work.

The service collected reliable data and analysed it. The service used systems to collect data from wards that were not over-burdensome for frontline staff. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The ward manager received a monthly data pack which outlined key data including the number of incidents, risk profile for the ward, restrictive interventions, medicines management, complaints and compliments, supervision and training, and any audits that had been undertaken.

The registered manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The daily situation report meeting was attended by all the ward managers in the hospital and reviewed staffing levels, patient observation levels, restrictive interventions, any incidents (including the auditing of relevant documentation), safeguarding and any new maintenance issues. The situation report dashboard supported the registered manager to have oversight across the hospital, including of Spencer ward.

Staff made notifications to external bodies as needed including the Care Quality Commission and the provider safeguarding team.

Staff had access to the equipment and information technology needed to do their work. However, slow computers and poor information technology were raised as an issue by all types of staff we spoke to. Information technology equipment in the nursing stations across all wards had been identified on the risk register in April 2021 as being slow and impacting on the efficiency and effectiveness of staff. Work had been undertaken in between May and September 2021 in order to address this and it had been agreed that laptops would be secured for the ward, these were not in place at the time of inspection due to a shortage of availability during the pandemic.

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.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The positive and safe group used the data pack produced for the ward to support changes and reduce restrictive practice. For example, the introduction of an activity coordinator to work afternoons, evenings and weekends. These were times when more incidents were recorded.

The ward manager actively engaged in the network for the local provider collaborative for South Yorkshire. The service had frequent contact and a quality working relationship with referring clinical teams and with NHS England specialised commissioning teams that commissioned beds.

Managers from the service were not actively participating actively in the work of the local transforming care partnership. However, they arranged care and treatment reviews when relevant.

Good

Forensic inpatient or secure wards

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Staff used quality improvement methods, particularly focused on the reduction of restrictive practices.

Staff were given the time and support to consider opportunities for improvements and this led to changes such as the introduction of activity organisers, new therapeutic roles and a sensory room.

Staff were not participating in research activities.

Staff were involved with several local improvement networks and profession specific groups. These provided opportunities to share best practice, engage in learning and reduce restrictive practices.

Spencer ward had joined the Quality Network for Forensic Mental Health Services scheme. They were working towards accreditation at the time of inspection.