Good

Mersey Care NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW493	Scott Clinic	Hawthorne Ward Ivy Ward Myrtle Ward Olive Ward Poplar Ward Reed Lodge	WA9 5BD
RW401	Rathbone Hospital	Childwall Ward Allerton Ward	L13 4AU

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated forensic inpatient/secure wards (medium and low secure) as good because:

- All wards had a ligature risk assessment in place. Security procedures that were in place for accessing the wards met the needs of each individual service and the level of security required.
- Clinic rooms were functional; medical devices were checked regularly and serviced and calibrated annually. Physical health was monitored routinely, and patients had access to a GP twice weekly if this was required.
- Risk assessments and care plans were in place for all patients. These were up to date and reflected the patients' needs. The majority of patients told us that they had been offered a copy of their care plans.
- Incidents were reported through the trust's electronic incident reporting system. Staff received feedback on incidents and complaints through staff meetings and quality practice alerts.
- Staff used National Institute for Health and Care Excellence guidance to guide their practice, and used recognised rating scales to monitor patient outcomes.
- Staff received supervision and annual work performance appraisals. Staff felt skilled and competent to perform their role and had lots of opportunity for additional training should they wish to develop their skills further.
- We observed positive and supportive interactions between patients and staff, which showed that staff treated patients with dignity and respect. Patients told us that staff were respectful and caring.
- The independent mental health advocate was available on thewards, and supported patients in ward rounds and with their concerns. Community meetings took place monthly.
- A referrals meeting took place weekly across the medium and low secure wards to review all referral, discharges and movements between the services.
- Both diversionary and occupational activities took place on the ward seven days a week. The majority of patients told us that the food was good, and they had access to hot and cold drinks throughout the day and could have snacks. Both units had a multi faith room and could access spiritual leaders to support their patients' cultural and spiritual needs. There was disabled access on both sites.
- Staff were aware of the vision and values of the organisation. Staff felt that there was a high presence of the matrons within the low and medium secure services.
- There were good governance systems in place for monitoring compliance with staffing sickness, mandatory training and appraisals. The ward managers felt that they had enough authority to perform their role and had access to key performance indicators, which helped to monitor the performance of their teams.
- Staff morale was good and there was evidence of good team working. Staff were able to provide feedback on their services through team meetings. They were also invited to send any feedback to the trust chief executive.
- All the wards were part of the quality network for forensic mental health peer review initiative.

However:

- At the Scott Clinic, the sluice on four of the wards was located within the patient laundry room. This did not apply good infection control principles for clean and dirty areas.
- Patients that were secluded at the Scott Clinic could potentially see the computer screens in the staff office which could cause a breach of confidentiality.
- The ward staffing levels meant there were not always enough staff on duty to meet the needs of the patients; patients and staff told us that leave often had to be rescheduled.
- The drug detection dog attended all the wards on a frequent basis. We felt that this practice was overly restrictive on low secure wards.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- At the Scott Clinic, the sluice on four of the wards was located within the patient laundry room. This did not apply good infection control principles for clean and dirty areas.
- The ward staffing did not always allow staff to meet the acuity and needs of the patients; often leave had to be rescheduled.
- The drug detection dog attended all the wards on a frequent basis. We felt that this practice was overly restrictive on low secure wards.

However:

- All wards had a ligature risk assessment in place. These were present on the wards and staff were aware of the risks that had been identified.
- All wards were single sex therefore complied with the Department of Health same sex guidance.
- Security procedures that were in place for accessing the wards met the needs of each individual service and the level of security required.
- Clinic rooms were functional; medical devices were checked regularly and serviced and calibrated annually.
- Risk assessments were in place for all patients and management plans were in place to show how each risk was managed.
- Incidents were reported through the trust's electronic incident reporting system. Staff received feedback on incidents through staff meetings and quality practice alerts.

Are services effective?

Good

We rated effective as good because:

- Comprehensive assessments of patients took place prior to admission. Care plans were in place for all patients which met their needs.
- Physical health was monitored routinely, and patients had access to a GP twice weekly if this was required.
- Staff used National Institute for Health and Care Excellence guidance to guide their practice, and used recognised rating scales to monitor patient outcomes.

Summary of findings

- Staff received supervision and annual work performance appraisals. Staff also had additional reflective practice sessions which they used to discuss complex cases and formulate care plans.
- Staff felt skilled and competent to perform their role and had lots of opportunity for additional training should they wish to develop their skills further.
- Staff had a good knowledge of the Mental Health Act and the Mental Capacity Act.

However:

- Patients that were secluded at the Scott Clinic could potentially see the computer screens in the staff office which could cause a breach of confidentiality.

Are services caring?

Good

We rated caring as good because:

- We observed positive and supportive interaction between patients and staff, which showed that staff treated patients with dignity and respect.
- Patients told us that staff were respectful and caring.
- Staff orientated patients to the ward on admission.
- There was a good presence on the wards from the independent mental health advocate who supported patients in ward rounds and with their concerns.
- The majority of patients told us that they had been offered a copy of their care plans.
- Community meetings took place monthly which gave the patients an opportunity to provide feedback on the service. These were also attended by the advocate.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- A referrals meeting took place weekly across the medium and low secure wards to review all referral, discharges and movements between the services.
- Both diversionary and occupational activities took place on the ward seven days a week.
- The majority of patients told us that the food was good, and they had access to hot and cold drinks throughout the day and could have snacks.
- Both units had a multi faith room and could access spiritual leaders to support their patients' cultural and spiritual needs. There was disabled access on both sites.

Summary of findings

- Staff understood the complaint procedure and patients told us that they knew how to complain.
- Staff received feedback on complaints through staff meeting and quality practice alerts.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the vision and values of the organisation. Staff felt that there was a high presence of the matrons within the low and medium secure services.
- There were good governance systems in place for monitoring compliance with staffing sickness, mandatory training and appraisals.
- The ward managers felt that they had enough authority to perform their role and had access to key performance indicators which helped to monitor the performance of their teams.
- Staff morale was good and there was evidence of good team working.
- Staff were able to provide feedback on their services through team meetings. They were also invited to send any feedback to the trust chief executive.
- All the wards were part of the quality network for forensic mental health peer review initiative.

Summary of findings

Information about the service

The forensic/secure wards that were provided by Mersey Care NHS Foundation Trust formed part of the trust's secure mental health division and provided high, medium and low secure mental health services. We inspected the high secure services as a separate core service and this will have its own individual report.

Medium secure services

The Scott Clinic in St Helens provided medium secure services for Merseyside and Cheshire. There were 56 inpatient assessment, treatment and rehabilitation beds for men and women suffering from enduring mental health problems. The five male wards were; Ivy, Hawthorn, Myrtle which were admission wards and Olive was a rehabilitation ward. There was also a 10 bedded step down facility, Reed Lodge, for patients working towards discharge. Poplar Ward provided assessment and treatment for female patients.

Low secure services

Rathbone low secure unit was on the Rathbone Hospital site in the Old Swan area of Liverpool. It provided mental health rehabilitation for men with severe and enduring mental health problems who were preparing to return to life in the community. The unit had two wards, Allerton and Childwall, each with 16 en-suite bedrooms. 'Wavertree Street' was central to the unit and provided structured leisure activities and joined the two wards together. It was decorated to simulate a street, with a café, telephone box and other amenities.

We last inspected the medium and low secure services together with high secure services in June 2015. The service was rated 'good' in all five domains.

Our inspection team

Our team was led by:

Head of Inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team Leaders: Lindsay Neil and Sharon Marston, Inspection Managers, Care Quality Commission

The team that inspected the core service comprised two CQC inspectors, two specialist advisors with current experience working within a secure inpatient setting and an expert by experience. An expert by experience is someone who has experience of using services or caring for someone who uses services.

Why we carried out this inspection

We undertook an announced focused inspection of Mersey Care NHS Foundation Trust because there had been a significant change in the trust's circumstances. The trust had acquired Calderstones NHS Foundation Trust on 1 July 2016.

We also planned this inspection to include high secure services (a new core service) and to assess if the trust had addressed some of the areas where we identified breaches of regulation at our previous inspection in June 2015 (published October 2015).

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?

Summary of findings

- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from staff and patients.

During the inspection visit, the inspection team:

- visited all eight of the wards at the two hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 32 patients who were using the service and two carers
- spoke with 39 other staff members; including doctors, nurses, psychologists, occupational therapists and social workers
- interviewed the matrons with responsibility for these services
- attended and observed three multi-disciplinary meetings
- looked at 37 care records of patients
- carried out a specific check of the medication management on all eight wards.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The patients we spoke with on the wards told us that they felt safe on the wards and that staff were kind, caring and respectful. All patients told us that they were orientated to the ward on admission but some of them told us that they had only received an up to date patient information leaflet a few days prior to our inspection.

Patients were generally happy with their care and treatment on the wards, however there were some concerns raised that compound leave or escorted leave could be moved due to staff shortages or staff being moved to other areas.

Patients on the medium secure service told us that, although there was not a lot of space in the environment, it was clean and well cared for.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that good infection control measures are in place to ensure the separation of clean and dirty areas of the laundry and sluice on the four wards identified

Action the provider SHOULD take to improve

- The provider should ensure that the privacy and dignity of all service users while they are in seclusion at Scott Clinic is maintained and monitored at all times.
- The provider should ensure that there are systems in place to ensure that the staffing levels support the needs of the patients and that monitoring of rescheduled leave as well as cancelled leave should be considered to support this.
- The provider should ensure that patients who are using seclusion cannot see the computer screens in the staff offices at the Scott Clinic.
- The provider should consider the necessity and rationale of the frequency of the drug detection dogs attending low secure wards.

Mersey Care NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hawthorne Ward Ivy Ward Myrtle Ward Olive Ward Poplar Ward Reed Lodge	Scott Clinic
Childwall Ward Allerton Ward	Rathbone Hospital

Mental Health Act responsibilities

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

Mental Health Act administrators and offices were based on site at both the medium and low secure site. Mental Health Act administrators were available and staff felt they could contact them at any point for advice and support.

Mental Health Act training was mandatory available through ELearning for staff to access and staff we spoke with were knowledgeable about the Mental Health Act.

Medications relating to patients' mental health treatment had been prescribed within the parameters of their T2 and T3 forms. A T2 form is a certificate of consent to treatment that is completed by the responsible clinician to record that the patient understands and agrees with the medication they are being given. A T3 is a certificate of second opinion, which is completed by an independent second opinion doctor when a patient does not consent or does not have the capacity to consent to the medication prescribed by their responsible clinician, but the medication is deemed necessary and can be prescribed without the patients consent. The forms were attached to each patient's prescription chart.

Detailed findings

Patients were informed of their rights regarding their detention under the Mental Health Act at regular intervals throughout their stay in hospital.

Patients had access to independent mental health advocates, who attended the wards regularly.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act. They were aware of the basic principles of the Mental Capacity Act and could describe instances where this may be considered or used.

There was a trust Mental Capacity Act policy which the staff could refer to for guidance.

All patients within the secure wards were detained under the Mental Health Act, therefore no Deprivation of Liberty Safeguards applications had been made.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The medium and low secure and rehabilitation wards were clean, tidy and well maintained on the whole. However, we did find that some of the furniture on the male admission wards at Scott Clinic was worn and torn, particularly on Myrtle and Hawthorne ward. The trust had ordered replacement furniture.

The medium secure unit had good lines of sight for all areas of the ward which allowed unhindered observation of the ward. The low secure wards were each built around internal court yards therefore were square in design. This meant that all areas of the ward could not be observed easily. This was managed through a high presence of staff on the ward and at night staff were placed in areas along the bedroom corridors which allowed staff to observe all of the bedroom areas.

All the wards had undertaken an environmental and ligature point risk assessment. The ligature risk assessments clearly highlighted the ligature risks associated with each ward. A ligature point is a place to which patients intent on harming themselves might tie something to strangle themselves. There were plans alongside each risk to show how these risks were managed to ensure the safety of patients in those areas. This included mitigation such as the removal of the ligature risk, replace with anti-ligature fittings, a room to be used under direct supervision, awareness of patient activity and patient observations.

At Scott Clinic we found that on Hawthorne, Ivy, Myrtle and Olive wards the patient laundry room was also used as a sluice room. A sluice room is an area of the ward that is used for disposing of soiled waste and storing items for cleaning such as mops and buckets. On these four wards the laundry room that patients accessed to use the laundry facilities to wash, dry and hang their clothing, also had a metal sink which was used for emptying dirty water from mop buckets, and to store mops and buckets. This increased the risk of cross infection by dirty contaminated water coming into contact with clean patient laundry; this would be increased further should there have been an outbreak of infection such as diarrhoea and vomiting.

When we raised these concerns with the trust they conducted a risk assessment of the area, and developed an action plan to reduce the risk of cross infection within this area. This included ensuring patient laundry was not left out in the laundry area and communicating additional infection control guidance on the use of the room to staff and patients. The trust ordered new sinks that were fit for the purpose of emptying contaminated water.

The Patient Led Assessment of the Care Environment for the condition and maintenance of the wards, Scott Clinic scored better than the England average in two out of three comparable areas, including 'cleanliness' (99%) and 'disability' (95%) but scored two percentage points below average for 'condition, appearance and maintenance' at 93%. Rathbone Low Secure Unit scored worse than the England average for 'cleanliness' (97%) and 'condition, appearance and maintenance' (94%). Patient Led Assessment of the Care Environment assessments are self-assessments undertaken by teams of NHS and private/ independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness.

The secure units were all single sex and therefore complied with the Department of Health standards for same sex accommodation. The bedrooms on the low secure wards at Rathbone Hospital all had ensuite bathrooms and there were additional shared bathrooms available. The medium secure wards at Scott Clinic, with the exception of Poplar Ward and Reed Lodge, did not have en suite facilities. There was one bathroom, a shower room and two toilets on each ward for the male patients to share. We saw that sharing the bathroom facilities was a regular discussion topic on the ward community meeting minutes, and how the impact of sharing these facilities could be minimised such as maintaining hygiene standards.

All wards on the medium secure unit with the exception of Olive Ward and Reed Lodge had seclusion rooms. During our previous inspection in June 2015, we identified that Myrtle Ward seclusion room did not maintain patients'

privacy and dignity. The trust had therefore closed Myrtle ward's seclusion room. During our previous inspection we also identified that the other ward seclusion rooms had the potential not to meet patients' privacy and dignity.

During this inspection, we found that the seclusion room on Myrtle Ward had been re-provided in a different area of the ward. We reviewed each of the seclusion rooms and found that the lay out on Myrtle, Ivy and Hawthorne wards were similar. Each seclusion room was situated on the corridor that led from the entrance to the ward. Staff conducted line of sight observations while patients were in seclusion from a window that looked into the seclusion room from the staff office. Staff had access to controls for the lighting and the heating from the office. However, there was no intercom or ways to communicate with the patient from the staff office. To communicate with the patient staff would leave the office and go to the main seclusion room door on the entrance corridor where there was a hatch that they would communicate through. The window which staff observed through had an external blind which would be pulled down to allow some privacy for the patients in seclusion if they were using the shower or toilet facilities. This could be pulled down half way also at other times to give patients some privacy. We found that when the blind was open fully, you could see directly into the seclusion room from the main body of the ward. We were told that this would not be open fully if there was a patient in seclusion. The toilet and shower facilities within the seclusion room did not have a separate partitioning door and therefore was unable to be screened off. Nurse call buttons were available within each seclusion room to enable patients to call for assistance.

On Poplar Ward, the seclusion room could be accessed from the day area or the bedroom corridor. The seclusion room doors both had vision panelled observation windows within them which had both internal and external controls. This meant that both the patient and staff could open the windows to allow them to see in our out of the seclusion room at any time. There was also a window within the seclusion room which looked out in to the courtyard area. This had a shutter on the outside of the window, which staff told us would be shut when patients were out in the courtyard to maintain the patient in seclusion's privacy. There was an internal blind also within this window but at the time was not in fully working order. There was a toilet and sink within the seclusion room this was also not able to be partitioned or screened off. Staff observed the patients in seclusion through the staff office window. As on the other wards there was an external blind which was used to maintain privacy and dignity when patients used the toilet and washing facilities. The heating and lighting controls were in the staff office also. There was no intercom or way to communicate with the patient in seclusion through the staff office again staff would leave the office and use the hatch in the door which was situated on the bedroom corridor to communicate.

We raised a concern with the trust that the seclusion rooms still did not maintain privacy and dignity for patients. This was of particular concern on Poplar ward. The policy and procedure for the use of seclusion and long term segregation states 'the level of observation of the patient is to be decided on an individual basis but must be at intervals of no longer than 15 minutes'. Those patients who were not observed on a continual basis whilst in seclusion would have the means to open the vision panels on both doors without staff knowledge. This could allow other patients, and visitors on the ward to see inside the seclusion room including whilst they were using the toilet or washing facilities. We also found that on all the wards that the use of the window in the staff office had the potential to not maintain the patient's privacy and dignity during times that patients were being observed. However, there is an acknowledgement that the observation panels within the main doors of the seclusion rooms would also create the same issues.

The trust reviewed all the seclusion rooms at Scott clinic to review the issues raised. The trust developed an action plan and put some remedial action in place. The trust fitted privacy curtains which were fitted with velcro over the vision panelled windows on the seclusion room doors in Poplar ward. There was a job raised to fix the internal blind in the window that led out to the court yard area on Poplar.

The seclusion room at Rathbone Hospital was based on Childwall Ward. We found this met the requirements and the standards of the Mental Health Code of Practice.

Clinic rooms on all of the wards were clean, tidy and well organised. The size of the clinic rooms varied, some being small others having larger areas, each held enough space for its function. We saw that medical devices such as thermometers and blood monitoring machines were

calibrated and had received an annual maintenance check. All stock dressings and syringes were in date and sharps bins had been labelled correctly. Fridge and room temperatures were checked daily.

At Scott Clinic the 'red bag' that contained the automated external defibrillator, emergency drugs and other equipment required for a medical emergency was kept in a central clinic room off the wards. All staff had access to the clinical room through the master key. It was the responsibility of the team that raised the call for a cardiac arrest or medical emergency to bring the bag to the ward. The clinic room was the responsibility of the primary care team who were based at the Ashworth site but attended Scott Clinic two or three days per week. Reed Lodge had its own 'red bag' that was kept in the ward clinic room. At Rathbone Hospital, the 'red bag' was kept on Childwall ward. We found all the 'red bags' were checked daily by staff, and the emergency drugs were all in date.

All staff carried alarms and keys which were attached to them in a key pouch at all times. There were clear security procedures in place for staff entering and exiting both the Scott Clinic and the Rathbone Hospital low secure services. Staff, visitors and patients could only enter the units through a reception area that had airlock doors and was controlled by the reception staff. Staff handed in their identity card to receive keys for the unit and would not be allowed access to keys unless they could provide their identification. Visitors would be greeted by a staff member and escorted around the building. The reception staff completed a key count twice daily and a perimeter check three to four times daily. Reed Lodge did not require the same level of security for entering and exiting the ward as it was not a secure ward. Reed Lodge was accessed through a buzzer and intercom system where staff would monitor and supervise the access. The alarms and keys were kept on the ward and signed in and out each day.

Safe staffing

The provider estimated the number of staff required for each ward through a twice yearly staff review panel. This was chaired by senior managers within the secure division and the head of nursing for the division. The ward manager for each ward presented their staffing figures for the ward including acuity, bank nurse usage, and current establishments. There then followed a discussion with the panel about whether the current staffing establishment met the needs of the ward, patient group and to maintain safe staffing levels.

Staff worked a shift pattern of three 12-hour shifts for three weeks then four long days the fourth week. The daily staffing establishments across the medium, low and rehabilitation wards varied. Olive, Myrtle, Ivy, Childwall and Allerton wards all worked on two qualified staff and three nursing assistants during the day and one qualified nurse and two nursing assistants at night. Poplar ward had an increased daily establishment of two qualified nurses and four nursing assistants during the day and two qualified and three nursing assistants at night. Reed Lodge had a lower daily staffing establishment of one qualified nurse and two support time recovery workers during the day and one qualified nurse and one support time recovery worker at night. The ward managers for each ward were additional to the numbers and were available Monday to Friday in the core hours of nine to five. Other allied health professionals and disciplines also worked within each ward. Each ward had allocated occupational therapists, psychologists and social workers. The ward managers for the wards felt able to adjust their staffing levels according to their acuity.

The medium and low secure wards had 205 substantive staff. In the period between 1 January 2016 and 31 December 2016 there had been an 11% staff turnover. The service had a qualified nurse vacancy rate of 9%, the equivalent of 7.39 whole time equivalent posts. Across all wards, the bank usage to cover sickness, absence or vacancies was 4,114 shifts, agency staff were used to cover 27 shifts and bank or agency staff did not fill 1,877 shifts.

Poplar ward used the highest number of bank staff with staff covering 965 shifts, Hawthorne ward followed with 679 shifts filled. Staff told us that this was due to the acuity of these two particular wards. The teams had an overall sickness rate of 10%, with Olive ward reporting the highest sickness rate of 16%, Myrtle and Childwall followed with approximately 14% each.

Staff told us that there was a high number of work related injuries that had been sustained which contributed to the high levels of sickness on the wards. We spoke with the matron for Scott Clinic who told us that there had been a number of absences due to work related injuries.

Requires improvement

Are services safe?

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

We asked for information from the trust about the number of staff who was absent due to work related injuries for the periods October 2016 to December 2016 compared to January 2017 to March 2017. There was 10 staff absent over the period October 2016 to December 2016, categorised as Patient Assault/Musculoskeletal Injuries. There was a significant reduction over the period of January 2017 to March 2017 with only one staff member absent due to Injury/Fracture.

We spoke to 10 patients and nine staff members from Allerton and Childwall wards all of whom expressed concerns that there was often not enough staff on duty. An example was given that leave was often cancelled; such as the Christmas pantomime due to staff shortages. Six of the 10 patients we spoke with told us that they had had leave cancelled due to shortage of staffing. Six of the nine staff we spoke to also told us that leave could be cancelled or postponed due to staffing. All of the staff we spoke with told us that the ward worked short staffed 'most days'.

We spoke to 22 patients and 18 staff within Scott Clinic from most of the patients and staff we spoke with there was a real sense that the staffing levels were low or there was not enough staff to meet the acuity of the wards. Staff told us that they were often moved across the unit to support the wards with fewer staff and greater acuity, which impacted on their ward being able to facilitate compound leaves and unplanned escorted leaves. This was particularly evident on Olive Ward which is a rehabilitation ward; patients here had more leave and were working towards stepping down to low secure services. Staff on Olive Ward told us that staff were moved from the ward around half of the time, and gave an example where the week prior to our inspection due to staff being moved planned leave could not go ahead.

The trust provided information on staff movements between wards on Scott clinic. We found that from 1 March 2017 to 18 March 2017 staff were moved on 60 occasions. The ward that had the highest number of staff moved to another ward was Olive ward. This happened on 39 occasions over this period. The number of hours staff members were moved for varied from half an hour to eleven and a half hours. The total number of hours for the 39 staff moves on Olive ward was 314. We asked the trust to provide information on any leave that had been cancelled for patients for the previous six months prior to the inspection. The trust told us that there had been no recorded cancelled leave of absences, that leave was rescheduled or postponed should the acuity of the ward not allow leave to take place. The trust did not keep a central record of how often patients' leave was rescheduled or postponed.

It was evident from speaking to patients and staff that leave was often moved or postponed across both the low secure and medium secure service. The exception to this was Reed Lodge where patients had large amount of unescorted leave. We were given examples of where leave had been cancelled or rescheduled, however, this had not been recorded as cancelled and we were unable to determine whether these were rescheduled.

There was medical cover arrangements in place that covered a 24 hour period. Staff told us that they were able to easily access the responsible clinicians and junior doctors both during the day and out of hours.

As of 27 January 2017, the mandatory training compliance for the medium and low secure wards was 89% against the trust target of 95%. Low secure unit Childwall ward is the only ward out of the eight to score above the trust target with 98% compliance.

Assessing and managing risk to patients and staff

The medium and low secure wards had 273 incidents of restraint involving 33 different service users and 101 incidents of seclusion between 1 January 2016 and 31 December 2016. There were 22 incidents of prone restraint, which accounted for 8% of the restraint incidents. Of the 273 restraint incidents reported, 16 (6%) resulted in the use of rapid tranquilisation. Poplar ward recorded the most restraint incidents with 234 across nine different patients. Seven of these incidents resulted in the use of 'prone' restraint, and 15 uses of rapid tranquilisation. The trust defined a prone restraint as physical restraint in a chest down position. Physical restraint that involves a service user being placed chest-down position for any period (even if briefly prior to being turned over) The ward also had the highest number of incidents of seclusion in the same period with 46. Ivy ward reported 16 incidents of restraint for the same period, with an equal amount of seclusion incidents (16). The restraints involved nine different patients with seven of the incidents resulting in the use of prone restraint and one use of rapid tranquilisation. Looking at the trends over the last 12 months, there appeared to be an upward trend in the number of

seclusion incidents being reported. Overall use of restraint appeared to have increased since our last inspection; over the six-month period 1 August 2014 to 31 January 2015 there were 81 restraints.

Staff we spoke with told us that there had been a significant shift in the care pathways and the functioning of the wards. This had led to an increase in the levels of acuity across the medium secure service which was reflected in the increased levels of restraints and seclusion episodes. However, staff were all aware of and understood the ethos of 'No Force First' and could describe how plans were in place for patients to understand early warning signs of escalation in agitation an aggression and how to manage this at an early stage to prevent further escalation.

The medium and low secure services used the short term assessment of risk and treatability risk assessment alongside the Historical Clinical Risk Management -20 to assess patient risks.

We reviewed 37 care records and found in all the records there were both Short Term Assessment of Risk and Treatability and Historical Clinical Risk Management–20 risk assessments in place that were up to date and reflected each patient's risk. Adequate risk mitigation plans in place. The Historical Clinical Risk Management-20 risk assessments were very comprehensive and gave a clear formulation and understanding of a patient's risk of violence.

There were a number of restrictions in place across the medium and low secure services, however, these were justified and risk based due to the patient group and the potential risks that they posed, such as access to prohibited items like glassware, lighters, energy drinks, and mobile phones. These were less restrictive as the level of ward security reduced for example, from medium to low secure and low secure to step down (Reed Lodge). Other restrictions in place were regular, random searches of the patients, the environment, and patients' bedrooms. These were completed in line with the trust policy. However, we did find that all of the wards within medium and low secure services received random visits from drug detection dogs. We asked for information from the trust for both medium and low secure service about how often the drug detection dogs had visited. From September 2016 to February 2017, the dogs had visited the medium secure service three occasions each month randomly and one targeted visit in September 2016. On the low secure service they received three random visits per month also. We recognised that the environmental risk may have warranted the use of drug detection dogs on medium secure, but felt this to be a restrictive practice on low secure wards. We reviewed the search policy for the trust which did not give a specified circumstance or frequency in which the drug dogs should visit.

We reviewed three sets of seclusion records which for the most part we found to be complete and compliant with the trust policy and the Mental Health Act Code of Practice.

There were 18 safeguarding referrals to local authorities reported by the medium and low secure services from 1 January 2016 to 31 December 2016. Seventeen were adult referrals and one was a child referral. Childwall ward made the most referrals in the 12-month period with six; this was followed by Hawthorne ward with four adult referrals. Ivy ward was the only ward to make a child referral in July 2016. No serious case reviews or direct notifications had been reported in relation to the medium and low secure units. Staff we spoke with were able to identify abuse, and were able to tell us the procedures for reporting safeguarding concerns both internally within the trust and externally to local authorities. Staff received training in safeguarding adults and children, we saw that overall the medium and low secure services were 93% complaint for both safeguarding adults and children.

There were family visiting areas on both the medium and low secure services. The social workers for the wards would be involved in assessing the suitability of child visiting on an individual risk basis.

Track record on safety

Between 1 November 2015 and 31 October 2016, the medium and low secure services reported 24 serious incidents that required investigation. Twenty-nine percent of the incidents were 'Pending review' (seven incidents) followed by 'Unauthorised absence' (25%, six incidents).

Four of the incident that were reported as 'unauthorised absence' were related to patients on the low secure unit at Rathborne Hospital. These were investigated and we were told that learning had been disseminated to staff and new management strategies had been put in place to reduce the possibility of further incidents. Learning that came from these incidents had also been shared across the secure division through a quality practice alert.

Requires improvement

Are services safe?

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

The Trust had a 'Being Open' policy which included information on the requirements for duty of candour. Staff we spoke to told us that they would talk to the patients or families about incidents that occurred, however, they were unable to tell us of any incidents that they had been involved with that met the threshold for duty of candour.

Reporting incidents and learning from when things go wrong

Staff reported incidents through their electronic incident reporting system. There were able to describe the types of incidents that would be reported and the systems in place in which these incidents were reviewed. Staff we spoke with told us that they received regular feedback through team meeting and supervision on incidents and any learning from incidents that had happened.

We saw that each ward had a file which contained information about incidents and learning from incidents from across the secure division. Staff also told us that they received debriefing sessions following any serious incidents with senior managers from the division. We reviewed four reflective debrief sessions following incidents of prone restraint which were reviewed by the division lead for No Force First. These looked at whether the incidents of restraint and prone restraint were justified and whether there was any learning from the incidents.

Staff also told us that they had regular reflective practice sessions to be able to reflect on current management strategies for more complex patients.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed 37 care records across the medium and low secure services. All the care records contained a detailed assessment of patients' needs. All the care records contained care plans that were holistic and recovery focused. These were all up to date and we found that they met the individual needs of each patient.

We saw some good examples of nursing care plans for physical health care concerns such as diabetes, food and nutrition and hypotension. These described the patients' needs, ongoing monitoring in place, signs for deterioration and any actions that should be taken.

All the care records we reviewed showed evidence that a physical health assessment had taken place at the point of admission. We reviewed each ward's 'well man' files. These contained monthly monitoring of each patient's physical health observations such as, blood pressure, temperature, pulse, and oxygen saturations. Modified early warning scores were used to determine whether there were was any additional follow up required.

The trust used an electronic care records system which meant that care records were stored securely. However, we did find that on the wards that had seclusion rooms at Scott Clinic, patients could see into the staff office whilst in seclusion even when the blinds were down. This meant that they could see the computer screens and therefore had the potential to breach confidentiality when staff were recording in patient records. We raised our concerns with the trust who took measures to order privacy screen covers for all computer screens across the site.

Best practice in treatment and care

We reviewed 24 prescription cards and found that all were thoroughly completed. We found prescription cards had all mandatory information such as name, date of birth, and allergy status documented. Where antipsychotic medication was above British National Formulary, we saw the recommended physical health care checks were taking place for those patients. We found some minor errors on the prescription charts where patients had refused their medication and the nursing staff had left the signature box empty. The procedure should have been to enter a number in the box to indicate the patient had refused. We spoke with the staff at the time who agreed that they would raise this issue with staff and complete an electronic incident form.

There were psychologists attached to both the medium and low secure services who were actively involved in the multidisciplinary team meetings and also provided a range of therapies on a one to one basis such as cognitive behavioural therapy, eye movement desensitization and reprocessing, and cognitive analytic therapy.

In the care records we reviewed we saw references to the National Institute of Health and Care Excellence guidance, which referred to quality standard 14: service users experience in adult mental health, also referenced nursing and midwifery guidelines, and the Mental Health Act Code of Practice within patients 'care plans.

Staff used recognised rating scales such as the Beck's Depression Inventory, the Liverpool University Neuroleptic Side Effect Rating scale, Modified Early Warning Scores, and Health of the Nation Outcome Scales – Secure.

There were a range of clinical audits that took place across the services from mattress audits, to Mental Health Act documentation, and other audits such as medication charts, infection control and care plans.

Skilled staff to deliver care

There were a full range of professionals employed to work within the secure services including doctors, nurses, psychologists, occupational therapists and pharmacists. Staff were experienced and qualified and had received additional training to support them in their role. Staff told us there were a number of different courses available for them to access such as personality disorder training, and leadership training for the qualified nurses. Staff told us that funding was also available for postgraduate training.

Staff received both a corporate and a local induction on commencing employment with the trust. Staff told us that they spent time on the wards shadowing the various roles within the secure services such as the security nurse before being expected to complete the role themselves.

Staff told us that supervision took place monthly in a formal setting with their line manager. Staff also told us that they could access more informal supervision as and when they required it. Reflective practice sessions took place on a weekly basis for reflection on complex patients

Are services effective?

Good

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or issues affecting the wards. The trust target for supervision was 90% of the teams to receive supervision in the previous 6-8 weeks on a rolling basis. The average clinical supervision compliance across all 10 teams was between 69% and 85% from 1 January 2016 to 31 December 2016.

Annual work performance appraisals were completed. The trust's target rate for appraisal compliance was 95%. As at 26 January 2017, the overall appraisal rates for non-medical staff within medium and low secure wards was 95%.

Throughout this inspection, staff told us that they felt supported, adequately supervised and trained to enable them to perform their role to the level expected of them.

Multi-disciplinary and inter-agency team work

We observed three multidisciplinary team meetings during our inspection. We found the meetings to be well attended by a number of disciplines. Each discipline was able to give verbal feedback and an update on their progress with the patient since the previous meeting. We found that patients' requests for leave and additional activity, and visits from family or children were carefully considered and therapeutic risk taking was evident. We saw that discharge planning was considered at each meeting and patients were kept informed of any changes with any hold up in funding, or referrals to other placements.

Handovers took place from the morning to night shift and night to morning shift. We did not observe any handovers during our inspection but we reviewed the handover files that were available for staff to refer to throughout the day. We found these to be detailed. They contained pertinent information about the patient, giving a brief synopsis of their presentation the previous shift, current risks, level of observation, physical health care issues and any additional medications given to the patient.

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

Mental Health Act papers were received on site by a qualified nurse. Papers were scrutinised and sent to the Mental Health Act administration office. Mental Health Act offices were based on site at both the medium and low secure site. Staff were aware of who their Mental Health Act administrators were and felt they could contact them at any point for advice and support.

As at 27 January 2017, the medium and low secure wards scored 30% compliance for the number of staff trained in the Mental Health Act. This course was mandatory for staff. All wards failed to achieve the trust target of 95% compliance. However, staff told us that this was a new ELearning program and there was a previous training on the Mental Health Act which they had all completed. The ward managers we spoke with confirmed this and told us that the compliance rate with the new training was improving.

We reviewed 24 medication charts and found that all medications relating to patients' mental health treatment had been prescribed within the parameters of their T2 and T3 forms. A T2 form is a certificate of consent to treatment that is completed by the responsible clinician to record that the patient understands and agrees with the medication they are being given. A T3 is a certificate of second opinion, which is completed by an independent second opinion doctor when a patient does not consent or does not have the capacity to consent to the medication prescribed by their responsible clinician, but the medication is deemed necessary and can be prescribed without the patients consent. The forms were attached to each patient's prescription chart.

Patients were informed of their rights regarding their detention under the Mental Health Act at regular intervals throughout their stay in hospital. Staff told us that this happened periodically throughout the year, when a person's mental state changes or their section under the Mental Health Act changes.

Patients had access to independent mental health advocates, who attended the wards regularly and would attend multidisciplinary team meetings.

Good practice in applying the Mental Capacity Act

The Mental Health Act and Mental Capacity Act training were delivered together therefore the training figures for the Mental Capacity Act were the same as the Mental Health Act and previous training figures showed that staff were compliant with this training.

Staff we spoke with were aware of the principles of the Mental Capacity Act and knew that there was a process to follow should there be a concern regarding a patient's capacity to make an informed decision. There was a trust Mental Capacity Act policy which the staff could refer to for guidance.

Are services effective?

Good

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

All patients within the secure wards were detained under the Mental Health Act, therefore no Deprivation of Liberty Safeguards applications had been made.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During our inspection we observed a number of activities and interactions between staff and patients. We found these to be positive, supportive and encouraging. We saw that patients were treated with respect and dignity.

Where patients were one to one observations these were completed discreetly and where the observation allowed these were noted to not be overly intrusive.

Patients we spoke with told us that staff were respectful and caring and the majority of patients told us that they felt safe on the wards.

The Patient Led Assessment of the Care Environment score for privacy, dignity and wellbeing, for the medium and low secure wards were better than or similar to than the England average of 90%. Scott Clinic however scored the lowest with 89%.

The involvement of people in the care that they receive

Patients told us that they were orientated to the wards on admission. Most of the patients we spoke with felt involved in their care and had received or been offered a copy of their care plan.

All patients told us that there was a high presence on the ward of the independent mental health advocate and the majority of the patients had the advocate involved in their care.

We saw that monthly community meetings took place on all the wards, where patients were able to provide feedback on the functioning of the ward including staffing levels leave, activities, and the environment. We observed one community meeting. The independent mental health advocate attended the meeting and supported the patients to air their views.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The trust provided details of bed occupancy rates for eight wards between 1 January 2016 and 31 December 2016. For the 12-month period forensic inpatient/medium and low secure wards bed occupancy ranged from 89% to 102%. These bed occupancy rates include leave days. The wards with the highest average bed occupancies were Hawthorn with 102% and Ivy with 100%. Reed Lodge reported an overall bed occupancy of 89% for the period.

The trust provided data on the number of patients moving wards per admission for the medium and low secure wards between 1 January 2015 and 31 December 2016. No patients were moved wards after 10pm, across all wards.

Between 1 January 2016 and 31 December 2016, discharged patients had lengths of stay ranging from 175 days to 1620 days across all wards. Childwall ward had the highest average length of stay across six of the 12 months with 1482 days. Ivy ward had the lowest average rate with 99 days. The high length of stay on Childwall ward was due to two patients who were discharged within the year who had a length of stay of over seven years and one of 10 years. These were discharged following an agreed change in the service specification for the low secure wards. The new specification meant that the commissioners wanted to move on longer stay patients and worked with the service to establish placements for these patients with complex needs. The remaining six patients had an average length of stay of two and a half years.

During the same period there were 50 discharges from the medium and low secure wards and 114 delayed discharges. A delayed discharge is defined as a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all other agencies, and who continues to occupy a bed beyond their discharge date. The main reason for delayed discharges from medium and low secure wards was that a 'step down' or community placement with another provider was not readily available.

Five of the wards/teams had the highest number of delayed discharges; these were Allerton ward (24), Myrtle ward (21), Hawthorne ward (20), Childwall ward (19) and Olive ward with 17. Staff told us the reason for the delayed discharges was a due to delays in accessing beds for patients to progress on to. This issue was highlighted in the service risk register.

The trust had identified on their risk register that there were concerns with the level of occupancy on the wards that could affect the flow of the patients coming into the service. All referrals and patients within the medium and low secure wards were discussed at a weekly referrals meeting to ensure that the service were aware of any issues that may affect admission and discharge and appropriate action or escalation could take place. The trust had also acknowledged that there were concerns in relation to delayed discharges from particularly the low secure wards. There were good escalation procedures in place and the trust were working closely with the local commissioners and locality areas for each patient to resolve any issues with blockages to funding or placements.

The facilities promote recovery, comfort, dignity and confidentiality

The medium secure wards had limited rooms on the ward to support activities. The clinic rooms were small but functional for administering medication. The wards would use patient bedroom areas or the off the ward clinic area for physical examinations. There was space off the wards in an occupational therapy area for activity, woodwork and a gym. There was a large compound area for males and one for females which patients had access to periodically throughout the day.

Visits, without children, took place on the wards. On the medium secure wards a private space for this was often limited. Patients that had leave granted with family and those who had children visiting could go off the ward or use the family visiting room. Both the medium and low secure wards had identified areas for child visiting.

The low secure wards were larger and therefore had more identified quiet areas on the wards that could be used for activity and one to one time. The low secure ward also had an off the ward area called Wavertree Street. This was a communal area for both wards which had access to a family visiting room, multifaith room, gym, and a large communal area for dining.

Each ward on the medium and low secure site had a room with a pay phone installed. This could be used for patients to make a private telephone call.

Are services responsive to people's needs?

Good

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

The majority of patients we spoke with told us that the food was good. Some patients told us that the food was 'not very good' or was 'tasteless and repetitive'; these comments mainly came from patients on Childwall and Allerton wards. The food provided on the medium secure wards was cooked on site, whereas the food provided on the low secure ward was served via a 'cook chill' method. The patients on Reed Lodge received a budget per week and bought and cooked all their own food as part of their rehabilitation program.

In the Patient Led Assessment of the Care Environment score for food the low secure unit achieved a better than average score of 95%, which was three percentage points better than the England average (92%). Scott Clinic scored similar to the England average at 92%.

We saw that patients had access to hot and cold drinks throughout the day. Patients were able to keep non-perishable foods in their rooms so they could access snacks throughout the day. We saw that patients were able to personalise their bedroom areas and had access to televisions and stereos where this had been risk assessed as appropriate.

The medium and low secure wards had activities seven days per week. These varied between occupational and diversionary activities. Patient had access to cooking, art and crafts, woodwork, health and fitness sessions, music lessons and a reading group. The majority of the patients we spoke with told us that there were plenty of activities that they were able to access. Five of the patients told us that they would like more activities that they could attend or told us that they were not interested in joining in the activities. We observed a number of activity sessions and interactions between staff and patients. We found that staff encouraged patients to get involved in ward based activities.

Meeting the needs of all people who use the service

The low secure wards were all on the ground floor and rooms and corridors were spacious and allowed access for those who required wheelchair access or adaptations for walking. There were three medium secure wards that were based on the first floor. There was a lift available for accessing the first floor. All the medium secure wards were smaller and had less space but all had a bedroom and a bathroom area that could accommodate anyone who required additional space or adjustments for disabled access.

Information leaflets were available on all the wards for patients that informed them of their rights, how to access independent mental health advocacy, and how to complain. Other information displayed in and around the wards gave information on activities available, health promotion, staffing levels, and staff team photos and names. This information was readily available on the wards in different languages. Staff told us that should this information be required in different languages this would be factored into the admission process and this information would be sourced prior to a patient's admission. Staff were aware of where to access this information should it be required. A translation service was available for staff and patients to access.

Staff supported patients' spiritual and cultural needs by supporting patients into the community to visit their place of worship where they had leave to do so. All wards could arrange for spiritual leaders to attend the wards for those patients who could not access the community. We were given an example of where staff invited a Buddhist monk to attend the ward for a previous patient. Both the medium and low secure sites had a multi faith room available for patients to use.

Listening to and learning from concerns and complaints

Medium and low secure wards received 19 complaints during the last 12 months (1 January 2016 to 31 December 2016). Of these 19 complaints, four (21%) were upheld, two (11%) were partially upheld and none were referred to the ombudsman.

Attitude of staff was the most common reason for complaints with six (32%), patients' property and expenses followed with four (21%), all aspects of clinical treatment with three (16%), policy and commercial decisions of the trust with two (11%) and hotel services (including food), personal records, patients privacy and rights and other all had one each.

Staff we spoke with knew the complaint procedure and could explain how they would support patients to

Are services responsive to people's needs?

Good

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

complain. Staff told us that lessons learned from complaints would be discussed at team meeting or within their 'joint thinking space' meetings. Information also came from the trust through their quality practice alerts.

Patients we spoke with told us that they knew how to make a complaint; this would either be to the nurse in charge or ward manager. The majority of patient told us that they would also use their advocate as point of contact as they would help them if they had a complaint.

Are services well-led?

Good

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

Our findings

Vision and values

The trust's vision is "to be recognised as the leading organisation in the provision of mental health care, addiction services and learning disability care."

The trust has four values which are:

- Continuous improvement
- Accountability
- Respect
- Enthusiasm

The staff we spoke to were very much aware of and could identify with the trusts vision and values. Staff also were able to tell us about the trust's 'Perfect Care' goals that these were zero suicide, no force first and a just and fair culture. Team objectives and staff annual work performance appraisals were based on the values of the trust. Staff told us that the matrons for the services were visible and approachable within the wards.

Good governance

There were good governance systems in place for the ward managers to have oversight of their ward's compliance in relation to sickness absence, mandatory training, and supervision and appraisal. The ward managers were able to access a dashboard which would allow them to see where their ward was in relation to their targets. The ward managers also told us that they had regular discussion regarding their compliance in these areas with their own supervision. Ward managers also received a monthly update in relation to their key performance indicators which helped them to manage the performance of their teams.

The ward managers we spoke with told us that they felt that they had enough authority to do their role and would be able to escalate any concerns they had to their line manager or other senior manager should they feel that safety or care was compromised.

The trust had a risk register, and there were seven risks on the risk register that specifically related to the low and medium secure wards. The trust had put measures in place to reduce or hold the risk. The staff we spoke to were aware that the trust had a risk register and that this could be added to. The ward managers told us that they would discuss any concerns with their line manager if they wanted to add anything to the risk register.

Leadership, morale and staff engagement

Staff we spoke with were not aware of any bullying or harassment cases with in the medium or low secure services. Staff told us they knew what the whistleblowing policy was and most staff said that they felt able to raise their concerns.

Staff morale on the whole was good amongst staff. Staff felt that the acuity and levels of observations could impact on staffing which often could lead to increased pressure on workload which could impact on the morale of staff at times. However, most of the staff we spoke with told us that they enjoyed their job and felt that the trust invested in them through additional training. Leadership training was available for all qualified staff.

Staff were given the opportunity to give feedback on the wards and service they worked within through team meeting. Staff also told us that there was opportunity to ask questions or give feedback to the chief executive in 'ask Joe' sessions.

Commitment to quality improvement and innovation

The medium and low secure wards participated in one accreditation scheme, the Quality Network for Forensic Mental Health Services. The medium secure division at Scott Clinic was peer-reviewed on 16 and 17 November 2016. A team visited the low secure site at Rathbone Hospital on 15 March 2016. Information had been collected through interviews with senior managers and clinicians, frontline staff as well as with patients. Reviews were completed for 2016 and action plans were put in place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: At Scott Clinic we found that on four of the wards the patient laundry room was also used as a sluice room. On Hawthorne, Ivy, Myrtle and Olive ward the laundry room that patients accessed to use the laundry facilities to wash, dry and hang their clothing, also had a metal sink which was used for emptying dirty water from mop buckets, and to store mops and buckets. This increased the risk of cross infection where dirty contaminated water was in the same space as clean patient laundry, this risk increased further should there have been an outbreak of infection such as diarrhoea and vomiting. This is a breach of regulation 15(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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