The Spinney

Quality Report

Everest Road
Atherton
M46 9NT
Tel: 01942 885300
Website: http://www.elysiumhealthcare.co.uk/locations/the-spinney/

Date of inspection visit: 11-13 September 2017
Date of publication: 20/03/2018

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The Spinney as good because:

- The service recognised the difficulties friends and families could have when a loved one is admitted into a secure service. The service had established and maintained a well-supported network for carers to exchange views and share their experiences, the carers' forum, which held regular meetings and events.
- The service had forged excellent links and partnerships with other organisations to enable it to facilitate opportunities for patients outside the service.
- The service had good links with other healthcare providers including opticians, dentists and podiatrists, which meant these providers would visit and offer services to patients on site without the need for them to leave the hospital grounds.
- Patients were actively involved in how the service was run, from community meetings in each ward to an active patient council, which was also represented on the governance committee. Furthermore, patients participated in staff recruitment panels and project committees focusing on specific service improvement and development initiatives such as developing the new ward.
- Managers and staff had appropriate systems and measures in place to ensure the safety of patients and staff.
- The service recognised the importance of physical health and wellbeing, with a range of initiatives encouraging a healthier lifestyle, including a 12 week fitness programme.
- Patients had access to a vast array of activities and therapies including a sports hall, gym and swimming pool on-site.
- Staffing levels were safe and staff knew their patients well, even when covering other shifts.
- Patient centred care focused on patient recovery and the individual's potential after hospital.
- Staff and patients felt valued and that their opinions would be listened to and respected.
- Staff ensured that patients' risk assessments were regularly reviewed and documented.
- Patients were not subject to restrictive practices which limited or infringed on their rights.
- Staff ensured that physical health checks and monitoring were done routinely and reflected patient co-morbidities and the use of medication, which required additional monitoring.
- The environment across the site was well maintained and situated within large peaceful grounds.
- Individual wards were kept clean.
- The complaints procedure was understood by the patients and carers, with posters displayed in each ward outlining the process.
- Patients were allowed opportunities to take part in their own care.
- Staff ensured that the emergency equipment and drugs were routinely checked.

However:

- Some ligature risks had not been captured on the ligature risk assessment audit.
- On one ward, we saw ligature scissors were attached to the office noticeboard in an office, which was often unlocked when staff were present. This was rectified when this was raised.
- Not all references of new employees were fully verified.
- Information about section 61 reviews was not always documented on individual care records though reviews were taking place as evidenced in other documents.
- Paper case notes and records were not always dated, though in most instances we were told the information was also captured electronically.

The complaints policy and complaint outcome letter did not explain the role of the CQC regarding complaints relating to the Mental Health Act.

Summary of findings

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The Spinney

Services we looked at
Forensic inpatient/secure wards

Summary of this inspection

Background to The Spinney

The Spinney is an independent hospital that is run by Elysium Healthcare Limited. It is registered to provide the following regulated activities:

• assessment or medical treatment for persons detained under the Mental Health Act 1983

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

The service provides medium secure, low secure and psychiatric intensive care services for male patients. It has 93 beds split over seven wards.

The forensic inpatient secure wards were:

- Hesketh ward, a 15 bed medium secure ward
- Hindsford ward, a 10 bed low secure ward
- Lever ward, a 15 bed low secure ward
- Shevington ward, a 14 bed medium secure ward
- Pennington ward, a 10 bed medium secure ward
- Rivington ward, a 16 bed medium secure ward

The rehabilitation unit was:

- Milford ward, a three bed rehabilitation ward from the low secure unit

The psychiatric intensive care unit was:

- Hulton ward - a 10 bed psychiatric intensive care unit

The Spinney was also developing a modern rehabilitation ward from the low secure unit to replace Milford ward. This was called the Coppice and was in a separate building within the grounds and a short walk from the main building.

All patients were detained under the Mental Health Act. The length of stay varied considerably by ward, with some patients having been admitted for long-term secure care and some new admissions especially on the psychiatric intensive care unit.

The service had a new general manager, who has applied to become the registered manager with the Care Quality Commission. This is the first time we have inspected the Spinney since it has been managed and overseen by Elysium Healthcare Limited.

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

Our inspection team

The team that inspected the service comprised of four CQC inspectors, a CQC Mental Health Act reviewer, a CQC inspection manager, two specialist advisors (an occupational therapist and a consultant psychiatrist) and an expert by experience. An expert by experience is someone who had developed expertise in relation to health services by using them or through contact with those using them.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme and continued commitment to inspect all services within a year of registration.

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we had gathered about the location and requested additional information where this was required.

During the inspection visit, the inspection team:

- visited all seven wards at the service, looked at the quality of the ward environment and observed how staff cared for and interacted with patients
- spoke with 39 patients who were using the service, in a focus group discussion or individually and met with representatives of the patients council
- spoke with managers or acting managers for each of the seven wards
- spoke with 28 other staff members from different disciplines including nursing, medicine, occupational therapy, psychology, administration, housekeeping, catering and maintenance
- interviewed the service director
- spoke with relatives and a representative from the carers forum
- spoke with nursing, occupational therapy, social work, medical, employee engagement and governance leads
- spoke with an independent mental health advocate
- attended a community meeting between patients and staff
- reviewed the service health and safety procedure
- observed the senior management team handover
- attended the managers morning handover
- received feedback about the service from a commissioner
- reviewed supervision documentation
- attended and observed a management hand-over meeting and two multi-disciplinary meetings
- collected feedback from 12 patients using comment cards
- reviewed seclusion and long term segregation paperwork for a patient
- looked at patient records including 63 prescriptions charts and 42 care and treatment records
- reviewed the monitoring of patients on high dose antipsychotic medication
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 39 patients across the service, from both forensic inpatient wards and the psychiatric intensive care unit.

Patients spoke highly of the care, treatment and support they received. They commented favourably about the quality of their medical and nursing care, stating staff treated them with dignity and respect.

Many patients said they felt safe and commented about the effective approaches used by staff to maintain safety and calmly manage any aggression. Patients who had previously been in seclusion said the staff had also treated them kindly and with respect whilst in seclusion. Patients told us about the extensive range of activities, therapies and treatments they had available to them. The treatments offered to patients helped them understand their forensic history and helped manage and reduce future risks. The activities enabled patients to develop meaningful interactions whilst developing their self-esteem. Many patients commented that there were normally sufficient staff to access activities and escorted leave and they got out on leave with the regularity that had been authorised. However, on Rivington and Lever wards patients mentioned though cancellations were rare, they could be delayed or moved to another time if staff were unavailable or there were other priorities on the ward. Patients felt the reasons for this could be better communicated to them at the time.

Most patients commented favourably on the cleanliness of the wards, with bedrooms being cleaned regularly. On

Summary of this inspection

Lever ward, a patient told us the cleanliness of the showers and toilets could be improved. Patients on three wards commented about a recent problem with mice and felt communication about this whilst managers dealt with it through pest control measures, could have been better. On Hesketh ward, we were told about toilets being blocked regularly, but the staff dealt with this each time.

Patients had confidence in staff and ward managers, telling us that they listened to their concerns and would try to resolve any issues they had. Some patients mentioned there was a mutual trust and respect between patients and staff. Patients said they felt that staff looked out for them and acted in their best interests. Many patients said that they felt involved in their care, stating they were involved in their care and treatment planning decisions. Two out of the 39 patients we spoke with said they felt their care and treatment plan could be better explained to them. Most patients spoke of their positive interactions with the medical staff.

In the psychiatric intensive care unit, we were told about the caring nature of the staff and that it helped make patients feel well and cared for. Patients spoke of courtyard leave being cancelled due to lack of staff. One patient felt there could be more opportunity to speak during ward rounds and was anxious about having to speak over others to be heard. Another said he had not received a copy of his care plan. Both patients felt that they had appropriate access to advocacy support.

Patients on all wards felt staff were respectful towards them, though two patients mentioned staff do not always knock before entering their respective rooms.

We received 12 comment cards from patients. Out of these 10 contained positive comments about the staff and their experience of the service, 1 contained neutral comments and 1 contained negative comments about their unhappiness at being detained.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- On one ward, we saw ligature scissors were attached to the office noticeboard in an unlocked office.This was rectified when this was raised.
- On Lever Ward some ligature risks had not been captured on the ligature risk assessment audit but this was immediately rectified when highlighted.
- Not all references of new employees were fully verified.
- Information about Section 61 reviews was not always documented on individual care records though reviews were taking place as evidenced in other evidence.
- However:
- Patient risks were identified on admission and were reviewed routinely.
- Staffing levels were safe and proportionate to the number of patients on each ward with low staff sickness levels and limited use of agency staff, though regular bank staff did cover some shifts, which was mitigated by the familiarity of the staff.
- Staff underwent a formal induction process supported by mentors whilst they received comprehensive training, preparing them for their role.
- The service had employed more staff to mitigate risks associated with having bedrooms away from the main patient area and as a result patients had improved access to their bedrooms
- The service environment was clean and well maintained with staff routinely conducting health and safety assessments, which encompassed ligature risk assessments as documented on individual audits.
- Use of restrictions and seclusion was limited, mitigated by use of de-escalation as the first point of call by staff. There were regular reviews of seclusion and long term segregation in line with the requirements of the Mental Health Act Code of Practice.
- Security and welfare of the patients on forensic wards was frequently reviewed by the nominated security nurse on those wards who ensured the whereabouts of all staff and patients was known at all times.
- Governance processes ensured safety was at the forefront of all considerations, with hospital managers reviewing aspects of safe care during the daily management handover.

Summary of this inspection

- There was evidence of systematic processes for reviewing incidents and learning lessons, which were shared with staff along with revisions to guidance and processes.
- The service held regular safeguarding reviews with safeguarding concerns a standard item on ward team meetings. The team of social workers led on safeguarding training and referrals and were available if staff needed further advice.

Are services effective?

Good

We rated effective as **good** because:

- Treatment models and staff were focused on recovery and rehabilitation.
- Care plans were comprehensive and individualised; staff worked with patients to ensure they were reviewed regularly.All patients were offered the opportunity to draw up and record an advance statement for their future care.
- Patients had good access to therapies, treatments and activities to assist in their continued recovery and rehabilitation. Waiting times for therapies and treatments were well managed with most less than a week.
- Physical health checks were offered regularly by the practice nurse who also monitored and reviewed the care of those on high dose anti psychotics.
- Staff had appropriate systems for ensuring the Mental Health Act and Mental Capacity Act were being followed
- Patients were informed about and given access to the advocacy service where needed. There were systems and processes in place to involve advocacy services when patients lacked capacity.
- The staff worked well together, in a manner whereby they could speak freely and openly.
- There was a programme to continue staff professional development, including the use of external presenters to train staff on a vast array of topics including the Mental Capacity Act.
- Staff received regular supervision and an annual appraisal.
- Managers and charge nurses ensured there were regular team meetings that allowed staff to learn and share best practice and concerns accordingly.
- A culture of sharing experiences and offering support was further evidenced by use of patients and staff as buddies for new patients and mentors for new staff.

However

Summary of this inspection

- Paper case notes and records were not always dated, though in most instances we were told the information was also captured electronically.
- On each ward we saw a poster displaying patients' right to complain to the CQC but the complaints policy and complaint outcome letters did not explain the role of the CQC regarding complaints relating to the Mental Health Act.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- We witnessed positive caring interactions across the service.
- Patients spoke positively about staff, commenting about the trust and mutual respect they were given.
- Carers, friends and families of patients, spoke highly of the care and treatment given to patients and the support offered to families alike.
- Patient involvement was evident in all aspects of their care, with opportunities to input into care planning and goal setting available to patients.
- Patient opinions were considered in all discussions regarding patient care.
- Patient involvement was encouraged throughout the service, with various activities and committees available for patients to voice their opinions and give feedback to help develop services.
- Care and activities were personalised to meet the needs of the individual rather than generic programmes.
- Support and help offered to staff was innovative and reflective of individual personal circumstances and the changing needs of each individual.
- Patients had opportunities to raise concerns and make suggestions to further improve and develop services and the opportunities available to them.
- There were real attempts to involve patients and carers in improving services and developing existing governance processes.
- Patients were involved in decision making to develop the service including staff interviews and presentations to staff, management and visitors.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- The service proactively responded to the individual needs of patients as physical health trainers worked closely with individuals to develop personalised fitness plans aimed to encourage healthy living and disease prevention.

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- The service had responded positively to an admission with complex care needs by redesigning and adapting the ward environment to facilitate his needs to ensure his care was delivered effectively with dignity and respect.
- There were clear systems, processes and pathways in place to accept and assess new referrals based on the individual's needs and current patient dynamics.
- Patients had access to a wide range of facilities that included a sports hall, well equipped gymnasium and a swimming pool on site. The service employed a personal trainer who worked with staff and patients to improve physical exercise.
- Staff had developed meaningful partnerships and links with community organisations were utilised to help patients in their recovery journey with real work opportunities, continuing the services focus on recovery. The service was responsive to feedback, concerns and complaints made by patients, which were acted upon promptly to address these when they arose.
- A comprehensive and diverse range of activities was on offer for patients to choose from.
- There was evidence of strong community working and partnerships to facilitate patients through their recovery journey beyond their stay in hospital.
- Activities were led by a committed occupational therapy team who developed activities, which recognised the holistic individual needs of the patients.
- Patients had access to spiritual and pastoral care according to their religious needs and individual preferences.
- Provision for friends and family encouraged participation and involvement in various aspects of the service whilst making carers feel more inclusive in the care patients received.
- There was a focus on developing patients with real life skills to prepare them for life beyond the service.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The senior management team and the ward staff all knew and respected the patients, their needs and their concerns.
- There were systems in place to involve patients and carers in governance processes to ensure the service was delivered as needed.
- Managers and staff had access to a 'real-time' performance dashboard for each ward that comprehensively detailed ward performance in relation to a number of factors such as care planning, risk assessment, activities, Mental Health Act adherence, physical health checks and NHS contract

Summary of this inspection

performance. Dashboards were utilised daily by staff and managers to oversee and ensure continuing improvement. Dashboards showed good adherence to performance targets across all the wards in the service.

- There was a firm commitment to continual improvement and development of services through continued professional development of staff and engagement of patients.
- The service had been proactive in capturing and responding to patients concerns and complaints. There were creative attempts to involve patients in all aspects of the service.
- The service was very responsive to feedback from patients, staff and external agencies with a culture of openness and sharing whilst learning together when things went wrong.
- Staff contribution and value was recognised by providing individual initiatives to benefit staff morale and team working.
- Supervision and appraisals were conducted in a timely manner and documented accordingly.
- Different departments within the hospital responded quickly to concerns and changes were implemented swiftly including those about general maintenance and catering.
- Staff felt supported by their line managers and the service management team.
- There were clear management and governance processes across the service.
- Effective leadership was provided across wards, departments and the service.
- The need to have familiarity amongst staff had been recognised with the provision of a dedicated bank of staff to cover any staff shortages across the service.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All patients at the time of our inspection were detained under the Mental Health Act 1983. We found good adherence to the Mental Health Act and Code of Practice across this location.

A Mental Health Act reviewer completed three monitoring visits of different wards in the months leading up to our inspection. During these visits, it was found that not all records regarding a patient's detention and capacity assessment were evident, recording of consent to treatment for patients on a T2 were not always evident, copies of section 17 leave paperwork were not given to all patients, information on patients' rights to contact their clinical commissioning group were not displayed. It was evident during our visit that most of these issues had now been resolved

Mental Capacity Act and Deprivation of Liberty Safeguards

We found staff knowledge of the Mental Capacity Act to be well developed across the service with an awareness of where to seek further advice and clarification if it was needed. There were training modules available for staff to develop or refresh their understanding of the safeguards and the service utilised visiting guest speakers to deliver learning through seminars. The use of independent advocacy services was evident when patients were deemed to be lacking capacity. There was no use of Deprivation of Liberty Safeguards at this service as all patients were detained under the Mental Health Act.

All patients were offered the opportunity to draw up an advance statement for future care wishes.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	Good
Overall	Requires improvement	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	Good

Notes

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

The wards provided a safe environment for the care of patients within the medium and low secure and psychiatric intensive care wards. It was evident that security and safety of patients and staff alike was an active consideration and was taken seriously throughout the service.

Ligature risks are items or places that pose a credible risk to those intent on self-harm because they can be used to cause strangulation. Identifying these and knowing the risk they pose is essential to maintaining a safe environment. There was evidence of regular ligature risk audits, to identify and review these risks, as part of the wider health and safety checks carried out by staff each month on each ward. Staff had an awareness of these risks and knew to refer to the ligature risk assessment when in doubt. Risk was classified as low, medium or high depending on a range of factors including the location and visibility to staff.

Items identified as posing a high ligature risk were then either locked away and intended for supervised access or managed through closer or frequent supervision and increased checking. This was mitigated further by individualised risk assessments on admission. Only those patients who could safely be managed with these risks were admitted onto those areas. Fittings across the service included piano hinges on doors, bathrooms and toilets, which had anti-ligature safeguards built into them, tap and shower fittings and curtain and blind rails held with strong magnets, which meant they were all collapsible. Wardrobe doors had lipped hangers, which prevented them from being used as potential ligature points. However, we did observe some risks that had not been captured on the ward's ligature risk assessments. This included television and game console cabling and cords that were not secured and so were loose and slacking on Lever ward. In most instances, these were in communal areas, where staff could maintain either visual contact or where there was a frequent staff presence. When we raised this with the ward managers, the managers ensured the risks were identified on the ligature risk assessment to ensure these risks would be identified and action would be taken to mitigate the risks.

Ligature cutters either were accessible in all wards, kept with the grab bag or in a cupboard and all staff knew how to access these in the event of an emergency. However, in one of the medium secure wards for ease of access, the ligature cutter and ligature scissors, one of which contained a concealed blade, were pinned to a notice board in clear view of those within the office. The office was left unlocked when staff were present and patients could sometimes enter unprompted as we witnessed when a patient walked into the office. We raised this with the manager of the ward as there was the real potential for serious and significant risk of harm. This was rectified by the end of the day.

Across all ward areas, the site entry and exit points were controlled, using a gated lock and key mechanism. The keys to the units were booked in and out by staff using a computerised locked cupboard system, located at the entry of each building. At the entrance to each ward, there was an air lock doorway, which was intended to ensure patients were kept safe, by restricting access to those who were permitted it.

All patients had access to outdoor provision. Some wards also had their own direct access to a secure courtyard area,

for patients to access fresh air. The fencing and grounds were well maintained and checked regularly by the security nurse to ensure the integrity of the perimeter fence and prevent patients going absent without leave. These areas had sufficient safeguards in place to prevent entry or exit by climbing over the walls and perimeter. Patients on the psychiatric intensive care unit and Lever ward had access to an internal courtyard, under staff supervision, the environment of which was checked before and after patients were to use it.

The wards were clean and well maintained. Patients commented favourably on the cleanliness of the wards. The furniture on all the wards was in a good state of repair and was clean. Some of the wards had recently been renovated and boasted a modern décor that the patients spoke favourably about. The wards felt relaxed and comfortable. We asked patients if they felt safe on the ward. All gave positive responses, except one who chose not to answer.

Seclusion rooms met the requirements of the Mental Health Act Code of Practice in relation to providing a safe environment for the management of patients presenting as a risk to others, including providing spacious environments with ventilation, heating and lighting managed remotely

and integrated intercom systems. Some seclusion rooms had en suite facilities within the room with toilet fitting within partitioned walls and anti-ligature fittings. Staff could discreetly observe patients in the toilet areas if required. Others had a toilet and shower in the observation room, with disposable urinals also available in the seclusion room itself, if patients could not or would not leave the seclusion area. The seclusion rooms had a large clock visible for patients to identify the time. The use of seclusion rooms for seclusion purposes or otherwise was documented and reviewed by the ward manager and by the management team, during morning handover.

On Lever and Shevington wards, we heard the seclusion room was occasionally used for other purposes. This included to temporarily accommodate a patient who had damaged his room during the night, leaving it in need of urgent repair to fix exposed cabling and other hazards. Another patient who did not have an en-suite bedroom was allowed to use the toilet and shower facilities in the observation lounge if the seclusion room was not in use. The service manager had advised the service was actively looking into how an en-suite could be added to his room but these considerations were in the early stages.

On Lever ward, there was a corridor and some bedrooms away from the main annex and the staff offices, which were not visible to staff at all times. Staff monitored this area by scheduled checks along the corridor.

There was a clinic room in each ward, which varied in size and contents present but which were all clean and tidy. Medicines were stored securely with access restricted to authorised nursing staff, one of whom was designated to hold the key for each shift. Certain medication, controlled drugs, require additional storage precautions and enhanced checks to ensure their safe usage. There were appropriate arrangements for the management of controlled drugs to prevent misuse. Medicines requiring refrigeration were stored appropriately. The clinic rooms and refrigerators were checked daily and documented by nursing staff to ensure that medicines were stored at the correct temperature and were safe to use. The wards had resuscitation equipment, including grab bags and a defibrillator, which were checked regularly to ensure they were working correctly and would be immediately available in a medical emergency. We saw evidence that the equipment were routinely checked. During our inspection, there was a medical emergency just off one of the wards and staff responded quickly and calmly gathering the appropriate equipment to respond. Electrical equipment had been portable appliance tested to ensure they were safe.

Audits of the clinic room, refrigerator and resuscitation equipment were carried out regularly.

The audits showed good levels of adherence to make sure that medicines were stored safely and emergency equipment was checked and maintained appropriately. Bedrooms had fire alarms and nurse call systems. Equipment such as fire extinguishers and electric equipment was checked annually by an external contractor, to ensure they were safe and in working order. Ward staff completed a monthly safety and hazard checklist to check a number of areas including health and safety, fire safety, infection control and electrical equipment. Records

showed that ward staff were promoting good health and safety practices in their areas and any identified shortfalls or hazards were discussed with managers, who would continue to monitor these and address them.

Safe staffing

New staff, including bank staff, received a comprehensive induction programme prior to commencing their roles on the wards. Agency staff received a general orientation and overview of key policies and procedures.

Health care assistants were positive about the training and support they received. All were assigned a mentor upon starting employment, and during their probationary period were given opportunity to work across the site with regular rotation from ward to ward.

The wards displayed the actual staffing levels on each ward for each shift. The actual staffing levels matched or exceeded those expected per shift. During the day, ward managers had sufficient autonomy to amend the staffing numbers based on the individual needs of the patients in their care, including if a patient required one to one care or required higher levels of observation or was in seclusion. During the night, the site co-ordinator was responsible for staffing cover across the site and could reallocate staff or call upon the site's staff banking pool or agency staff if required. Patients told us that there were sufficient staff on the ward to provide appropriate care and treatment including named nurse sessions, facilitating escorted leave and attending medical and hospital appointments.

Patients on Rivington ward previously did not have access to their bedrooms at all times as some of the bedrooms were located on the first floor. This had now been mitigated by employing more staff to supervise the stairwell and upstairs corridor. However, we found that there were access restrictions each weekday on all three medium secure wards, to allow housekeeping to clean the bedrooms and to encourage patients to attend activities. Staff told us that if a patient wanted to use their bedroom, they would not be prevented in doing so during this time, but they would require a staff escort.

The secure wards had a security nurse, whose responsibility for each shift was ensuring the safety and security of all on the ward and who was designated responsibility to ensure regular checks were conducted. This included checks to ensure that there were no breaches in the ward perimeter and that items not permitted or permitted under supervision were not present in patient areas. On Milford ward, which was a rehabilitation ward, patients were allowed more responsibility with access to a wider range of items in keeping with the positive risk taking approaches deployed by the site.

Staff told us they felt safe on the wards and supported by both colleagues and managers to maintain appropriate relational and actual security. Staff understood guidance on maintaining appropriate actual and relational security within mental health secure settings.

The staffing plan for each ward was to have six members of staff on shift during the day including a minimum of two qualified nurses and four on shift during the night including a minimum of two qualified nurses. This allowed for appropriate staff to patient ratio across the wards. This was in addition to the ward managers, many of whom said they were available if they were required to work on the wards delivering care or helping with individual patients. The establishment levels for the service were 58.8 whole time equivalent qualified nurses and 111.5 whole time equivalent healthcare workers.

Across the service, there were nine nursing vacancies and seven healthcare worker vacancies. On each ward where there were some vacancies, there were well developed plans to recruit to these posts.

The service had its own bank of staff that were staff who were employed by the service and who were regularly used across the service. There was low use of agency staff with 18 shifts filled by agency health care assistants during July to September 2017. The service did not use qualified agency nursing staff and utilised overtime and bank nursing staff wherever required.

The service had a sickness rate of 2.5% for nurses and nursing assistants between August 2016 and July 2017

Staff and patients across the service told us that there were sufficient number of staff to meet patients' needs, though some patients did comment about last minute changes that could lead to activities being cancelled or postponed. Our observations showed that staff dealt with patients' requests in a prompt and respectful manner. There was a friendly rapport between staff and patients across the wards with staff demonstrating that they knew the patients,' their needs and concerns well, which helped with the relational security aspects of running secure wards.

Leave and activities were not routinely cancelled. The exception was in Rivington and Lever wards where patients commented that leave could be rescheduled occasionally when there were not sufficient staff to supervise activities or patient leave and that the reasons for this were not always communicated to them. This was confirmed by staff who said, if there was an incident or staff sickness, activities could be rescheduled. No documented records were available to verify this.

We reviewed personnel files for three members of staff. This showed that appropriate recruitment checks were made. this included disclosure and barring screening, checks to confirm staff suitability, qualifications, ability to work and professional accreditations and registrations. However whilst most references were verified, we saw some references which were not as they were not on headed paper, stamped with a company stamp or from a verifiable email address.

Ward staff worked on a two shift rotation system, working long days and then and through the night. This helped continuity of care with patients being cared for by the same staff for longer periods. Staff attended effective handovers to ensure they understood current patient presentations and manage risks more effectively on the ward.

The uptake of mandatory training completion levels across the service were an average approximately 90% for substantive staff. There was a good completion rate for immediate life support training, with 91% of staff having completed it. All of the mandatory training exceeded 83%, which meant that the majority of staff received updated training as required.

Assessing and managing risk to patients and staff

We looked at 26 patient records, including individual risk assessments. Patient risk assessments were up to date and identified the risks patients posed to themselves or to others. Risk management plans were evident. Various tools had also been used for assessing risk, including Historical Clinical Risk Management-20 and Short-Term Assessment of Risk and Treatability. Risk assessors had access to comprehensive set of professional guidelines for the assessment and management of risk relating to offending history.

We found well-completed initial risk assessments and evidence that risk was reviewed regularly. There were appropriate arrangements to ensure risks were considered when patients' leave status was reviewed and when they moved to different levels of security. For example when patients moved from medium secure care to a low secure care ward.

Staff from the psychology team were assigned to each ward and led on completing the comprehensive Historical Clinical Risk Management-20 tool to identify and manage ongoing risks. The psychology team would also attend the first review following admission.

We assessed prescription records, reviewing over 50 prescription charts and records, and spoke with nursing staff that were responsible for medicines administration. Across the service, the medicine administration records were well completed with no gaps noted in the medicines charts we observed.

The service's medicines supply and pharmacy support had until recently been provided by a national chain. A new agreement was due to come into place with a new pharmacy provider in the coming weeks. This would include the provision of emergency medication and patient information leaflets. Nursing staff we spoke to did not identify concerns with the availability of medication and stock medication including out of hours. There was evidence of routine stock audits and checks to both stock medication and the patient's own personal medication to ensure they were safe for use. Across the service there was a systematic process for reviewing prescription cards on all wards.

In encouraging independence and furthering individual rehabilitation, patients on the rehabilitation unit Milford ward, had a lockable cabinet to store their medication as part of their self-management of medication.

The service kept a register of patients on high dose anti-psychotic medication. High dose anti-psychotics refers to the administering of higher than the normal recommended dose of anti-psychotic medication. High dose antipsychotics were sometimes used when patients failed to respond to treatment at standard dose and their prescribing doctor deemed their condition required it, in order to maintain their safety and wellbeing. Due to the increased risk of prescribing antipsychotic medication above recommended levels, there was a need for additional monitoring and observations to ensure safety and wellbeing of patients. We case tracked all 10 patients who were on high dose antipsychotics. The service had a

register, which included monitoring forms for each patient on high dose antipsychotics, to keep managers up to date. The monitoring form included a record of known risk factors such as heart, kidney or liver problems for each patient as well as showing a record of the calculation of the percentages of each antipsychotic compared to the maximum recommended guidance. This referenced the British National Formulary, a reference book that contains authoritative information and advice on prescribing medicines including indications, contraindications, side effects, and recommended doses. Further details captured showed the clinical justification for the continued use of high dose antipsychotics including details of previous relapses in patients' mental health when reductions in medication had been tried. The information contained here was then reviewed in the management handover each morning.

There was good evidence of regular physical health checks being offered to patients led by the practice nurse to ensure any adverse effects were monitored and appropriate action taken. There were two patients on high-dose antipsychotics that regularly and routinely refused physical health checks, such as blood pressure and heart rate. In some instances when these patients did refuse these physical checks, their respiratory rate, which is a visual observation of a patients breathing and which can an early indicator of side effects and health deterioration, was monitored and documented.

We found that where checks were essential to continuing on a particular medicine, such as clozapine, that these did occur.

On occasions, patients may be prescribed medicines known as rapid tranquillisation to help with extreme episodes of agitation, anxiety and sometimes violence. We saw information about the use of rapid tranquillisation and the provider had an up to date policy covering this type of treatment. Nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate following administration of rapid tranquilisation. The corresponding care records for patients who had been given rapid tranquillisation showed clearly that these observations had been recorded.

On the PICU and secure wards, there were clear list of items not allowed on each ward which varied depending on the nature of the ward. These items were kept in security cupboards with access to these items under supervision only. There was an appropriate balance between managing risks within the secure and PICU environments and an appropriate level of positive risk taking. This was achieved through ensuring proper regard to relational security such as good knowledge of individual patients and appropriate staffing levels. When patients moved to Milford ward, they had ready access to a wider range of domestic and personal items in keeping with a rehabilitation unit.

During the six months prior to inspection, 1 January 2017 to 30 June 2017, there were 174 incidents of restraint on 31 patients across The Spinney. Most restraints occurred on Hulton ward, the psychiatric intensive care unit, which accounted for 82% of restraint episodes. Of all of the restraint incidents, 34 involved face down or prone restraint which was used for a short period of time. The service monitored the use of prone restraint to ensure it was only used when necessary and for the shortest period. The audit of prone restraint identified that prone restraint episodes were for very short periods and were mainly used due to the unexpected unintentional descent to the floor when patients were first restrained, as part of a controlled descent in the prone position to administer intra-muscular injection to patients or to enable staff to exit the seclusion room safely. National guidance from the Department of Health, Positive and Proactive Care, states that prone restraint should be avoided where possible. This is because there are dangers with prolonged prone restraint such as patients being at higher risk of respiratory collapse. There was information displayed to remind staff that prone restraint should only be used as a last resort and for the shortest possible time. There was a reducing restrictive practice group that regularly met to look to reduce and remove restrictive practices across the service in keeping with the varying levels of security in operation.

Staff were aware of de-escalation strategies to be used with patients exhibiting disturbed behaviour at the Spinney. The service had a protocol on de-escalating patients' disturbed behaviour in the observation lounges. This informed staff that if the patient was prevented from leaving the observation lounge that the safeguards of the Mental Health Act Code of Practice should be used. We spoke to staff regarding de facto seclusion in the observation lounges. De facto seclusion is a way of describing a situation where a patient is prevented from leaving an area or room, but without having the safeguards of the Mental Health Act applied. Staff appeared clear about the

requirements and had received appropriate training and guidance.. This was corroborated by the records we saw where no concerns about de facto seclusion were identified. The management team oversaw and reviewed the use of long term segregation regularly.

There had been 44 incidents of seclusion in the preceding six months. Some of the patients we spoke with had been secluded over this period. They confirmed that during seclusion staff continued to treat them well, with dignity and respect and they expressed no concerns over their experience.

Records documenting when seclusion occurred showed that many of the safeguards and reviews required when seclusion was used were met. The reasons for seclusion were clearly recorded and observations of patients were recorded every 15 minutes as required. The service policy required that the independent mental health advocate should be informed for each episode of seclusion to help ensure that the patient was offered support whilst in seclusion. However, it was suggested to us by some staff and patients, that the advocate was not always informed about seclusion episodes.

There were eight episodes of long term segregation involving three patients at The Spinney between January and June 2017. These incidents of long term segregation occurred on four different wards.

During long term segregation, patients would be nursed in a separate area, often their bedroom.

They were prevented from having contact with their peers due to their presentation over a continuing period rather than an isolated incident of disturbed behaviour. When patients were placed on long-term segregation they would have regular reviews including medical, nursing and multidisciplinary reviews. When patients were in long term segregation over a sustained period, independent reviews were carried out by nursing and medical staff from other hospitals run by the provider in the North West. The provider had a current long term segregation policy dated April 2017.

Long Term segregation care plans were reviewed during our visit. Records for the patient captured information regarding legal, positive behaviour support, therapeutic management of violence and aggression, detention history, Section 132 rights and proposed engagement plans. We also found evidence of management planning including discharge planning and evidence of regular reviews including an independent review by a consultant from another hospital within the same provider group. We saw an independent review for a patient with learning disabilities who was in long term segregation that had been carried out by a forensic psychiatrist rather than a consultant psychiatrist with expertise in learning disability without any rationale given for this. There was no evidence to suggest there had been any adverse impact of this.

Staff understood their responsibilities in reporting safeguarding concerns and were able to identify signs of abuse or neglect. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial training and then complete an annual refresher training. Across the service 86% of staff were up-to-date with their safeguarding training. Staff demonstrated a sound understanding of safeguarding procedures and what to do when faced with a safeguarding concern. The service had notified us of safeguarding alerts in a timely manner leading up to the inspection. In each of these cases it was clear that the service had taken appropriate action to safeguard vulnerable patients.

All the wards had systems and processes in place to deal with foreseeable emergencies including medical emergencies and fire evacuation. We saw the emergency equipment and ligature cutters were accessible. Staff were trained in the prevention and management of violence and aggression with an uptake rate of 99%. Staff were equipped with alarms and would use these to call for assistance from other staff members and there were systems in place for responding to an emergency, which we saw first-hand when the alarms were activated as a precautionary measure and staff responded from the ward and other parts of the service too.

The appropriateness of family visiting including whether children could visit was assessed by the team of social workers employed by the service. In making this assessment social workers contacted relevant authorities and made the arrangements for children visiting where this was deemed to be in the best interests of the child. There were family visiting rooms off the ward areas so children could visit patients at the service without having to go on the ward environment.

Track record on safety

Good

Forensic inpatient/secure wards

We looked at the incidents that had occurred recently at this hospital. All independent hospitals are required to tell us about any incidents and certain events by sending us the appropriate notification. The service had notified us of appropriate relevant events including safeguarding incidents and incidents, which required police involvement.

There had been eight serious incidents in the past twelve months prior to this inspection. The incidents included loss or inappropriate transmission of confidential information, incidents of self harm, suspected overdose on stock piled medication, and a patient on patient assault. There had been no episodes of patients going absent without leave. Managers had taken appropriate action to manage these incidents.

All the ward mangers and the senior management team at the Spinney had access to a wide range of performance indicators that were used to monitor safety information for each ward illustrated as real time dashboards. These captured patient details, observations levels, seclusion and long term segregation use, incidents, leave episodes, risk assessments, evidence of recent physical health checks and other key performance and safety data for each ward. Governance arrangements were in place to ensure there were appropriate reviews of the dashboards, incidents and complaints, and action on audits.

Reporting incidents and learning from when things go wrong

Staff were aware of how incidents should be reported and whose responsibility it was to record this. The provider used an electronic incident recording system. Senior managers, doctors and ward managers all attended a morning handover meeting where incidents were reviewed, including the learning from these and actions planned. During the monthly team meetings, staff would look at incidents in terms of the broader actions taken and lessons learned to ensure an understanding of the key lessons was maintained across the service.

When incidents occurred there was a debriefing session, which looked at what led up to the incident and was an opportunity to help staff consider issues that had arisen, so to help inform them of how things could be done differently in the future. There was a strong ethos of staff from a range of disciplines working together with incidents considered as a whole organisational responsibility. Staff also told us about the culture of learning from when things go wrong and how everyone understood this. Staff did not have any reservations about reporting concerns and worked without fear of any negative consequences of raising concerns if they needed to be raised.

Managers and staff were aware of their responsibilities in relation to duty of candour, which was the legal responsibility requiring all staff to be open, transparent and offer an apology when an incident occurred resulting in patient harm.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at the care and treatment records of 42 patients. The care plans we reviewed were up to date, showed personalised holistic care and were recovery orientated and goal focused. Patients we spoke to told us they were involved in care planning and all had been offered copies of their care plans, though not all would accept. This was captured accordingly in the documented notes. Patients were involved in care plan reviews with the multidisciplinary teams at review meetings, with many confirming they were treated with respect and dignity. We witnessed the team engaging and encouraging patient participation and meaningful collaborative dialogue occurring in discussions around risk and treatment plans. However we were told by some patients that patients would only be invited in towards the end after initial discussions and conversations had concluded, which some felt limited how much they could offer and input into those review meetings.

We observed two ward rounds. Everyone was able to contribute including patients. However, some patients mentioned they felt they had to talk over others at times to be heard.

The meetings followed the ethos seen throughout the site, to work in real time and so decisions or changes to the care plan decided during the meeting were inputted directly into the electronic notes and all present could see this on the projected screen.

There was a team dedicated to monitoring physical health, which was led by a full time practice nurse. A GP visited the service regularly and worked closely with the practice nurse. The GP registered patients and referred for specialist acute hospital advice as needed. The service had access to urgent out of hours GP provision. Other health professionals, such as dentists and opticians, visited at regular intervals.

Electronic dashboards monitored the completion of a physical assessment within 24 hours of admission and the provision of ongoing physical care. There was evidence these were routinely being done. There were instances when patients refused physical examinations, and staff followed the providers capacity and best interest policy, respecting patients right to choose when they had capacity.

There was noted good practice in the form of arranging blood tests and routine electrocardiogram on admission. Monitoring of cholesterol and blood sugar management was also completed routinely. Support for long term conditions including diabetes, epilepsy and asthma were also evident.

Physical health care plans were completed to a good standard. The use of specific assessment tools to monitor and review health needs was also evident. This included monitoring nutritional status using Malnutrition Universal Screening Tool scores and pressure area assessments using the waterflow tool. Additional care plans were noted for those at risk of self-harm with the harm minimisation plans.

The ward staff recorded routine physical observation checks for all patients at least once a month.

There had been several initiatives to help improve physical health and encourage weight loss. This included increasing provision of physical activities available for patients, such as the walking groups and more structured programmes. The 12 week “Mission Fit” programme was one such initiative co-ordinated by the physical health and OT teams. This was run by a dedicated fitness instructor in conjunction with the practice nurse. The main aim of the initiative was to introduce concepts of physical fitness and healthy eating to the patient group. Patients we spoke with generally gave positive feedback about their involvement in this and clearly enjoyed it.

Care planning was also evident in other areas with specific specialised templates including those for supporting substance misuse, making feasible plans, better life skills and reducing problem behaviour. The electronic system used for documenting care also enabled patients to input directly their thoughts and agreement to individually developed plans and goals set.

The service, after extensive conversations with commissioners and CQC, had recently admitted a patient whose presentations differed to those it normally cared for. The patient had severe learning disabilities and his condition required individualised care and long term segregation. The service had adapted to meet his care needs by facilitating his admission within its psychiatric intensive care unit, ensuring an appropriate positive behaviour plan and support were in place.

In facilitating the continued care and treatment of a patient with specific needs outside the services usual remit the service continued to closely work with commissioners and other partners to ensure he was receiving the most appropriate care possible. This had included facilitating regular care and treatment reviews and consulting with specialist about various aspects of his care including the provision of positive behavioural support plans.

Best practice in treatment and care

Staff had a general awareness of evidence-based practice and guidance, including for example the National Institute for Health and Care Excellence guidance relating to violence and aggression and schizophrenia. Staff used best practice guidance when formulating care plans and making prescribing decisions. Care plans also referenced specific national policy, guidance and research.

The provider did not permit smoking on hospital grounds and continued to offer smoking cessation support to patients including prescribing appropriate medication for this purpose in accordance with national good practice.

Psychological therapies and interventions were widely available across all wards. They were delivered by the nominated members of the clinical psychology team, who were assigned to each ward. This included one to one sessions and evidence based group interventions.

There were individual and group based sessions available in a wide range of therapies. They included a programme for reducing violence, ‘life minus violence’ programme, therapies for reducing inappropriate sexual behaviour, substance misuse support groups, groups for developing self-esteem including motivational skills, anxiety

management and problem solving. Individualised programmes were also available depending on the needs of the patient. Access to these was either by self-referral or referral via the multi-disciplinary team.

The records we reviewed all had a psychological assessment completed. Patients we spoke with told us that they were engaged in psychosocial support interventions or therapies. There was recognition of the fact that some patients would not be comfortable in a group environment and for them individual sessions would be offered. This would normally be done through the care programme approach meetings each individual patient had.

Risk assessments were initiated upon triage and completed within seven days of admission using evidence based tools including the Historical Clinical Risk management 20 and Short Term Assessment of Risk and Treatability tools. Other assessment and rating tools to be used included the Health of the Nation Outcome Scales, symptom rating scales and regular use of medication side effects questionnaires. There was evidence showing these tools and others were regularly used.

Audits were undertaken to monitor completion and regular reviews of care plans, which would then be captured on one of the dashboards and reviewed by the senior team during the management handover meeting.

The service actively participated in the prescribing observatory for mental health, which is run by the Royal College of Psychiatrists.

Skilled staff to deliver care

The multidisciplinary team comprised staff from medical, nursing, social work, occupational therapy and psychology disciplines, which were all well-staffed departments from the service. The multidisciplinary team welcomed contributions from all staff. Healthcare assistants had the opportunity to contribute to both multidisciplinary team meetings and ward rounds. However some felt it would sometimes be advantageous to also attend ward rounds, which at present they were not able to.

Staff spoke positively about the support available to them to develop their skills and understanding. They had access to training and development opportunities to both ensure they could do their current role but also to allow them the opportunity to progress in their careers and respective staff grades. This included diploma opportunities for healthcare assistants. Protected learning time was available for staff to do this, whilst their shifts were covered by colleagues. Likewise staff were able to come and attend training opportunities when not at work and through agreement with their line manager this time could be claimed back.

Staff supervision across the wards appeared to be in line with the provider's policy, occurring every four to six weeks. This occurred either individually or as group supervision. Staff could request more frequent supervision if they wished.

Staff meetings were held once a month and there was an opportunity for staff to raise concerns or any issues they may have.

Staff received an annual appraisal of their work performance and the service had a set target of achieving 90% of this within the timeframe. The service had an above 95% completion rate for staff appraisals within the intended period.

Qualified nursing staff reported feeling supported to develop their skills. Several staff mentioned leadership and management training was available.

There was a series of progression points for healthcare assistants and nurses with increased pay and more responsibility dependent on them meeting pre-requisite threshold and after completing a portfolio and competency based interview.

Multi-disciplinary and inter-agency team work

We heard positively from patients, staff and carers about their experience of the multidisciplinary team. This was reinforced in our observations and evidenced in meeting minutes. Staff had a good understanding of the different roles across the multi-disciplinary team and there was confidence to approach different disciplines and seek their expertise constructively. It was felt by staff and patients alike, that the staff from the diverse disciplines were approachable and they felt a trusting and respectful relationship existed with them all. Regular multi-disciplinary team meetings were held across all wards, at least once week. We observed two multidisciplinary team meetings. Different clinical, health and social care professions collectively worked well to assess and plan patient care and treatment. Patients were the focal point to the discussions and decision making.

Good

Forensic inpatient/secure wards

The service worked well with other organisations to deliver a holistic recovery centred approach. External care co-ordinators were invited to attend both ward rounds and care programme approach meetings, and where they could not due to whatever reason, the service were able to facilitate a video conference with them. This included a local pharmacy, opticians, dental and GP practice.

Adherence to the MHA and the MHA Code of Practice

Understanding of the Mental Health Act and its related code of practice amongst the staff was good. The senior Mental Health Act administrator had recently left and some of the duties of the role were being covered by the lead administrator, with other duties now being delegated to ward staff.

Before leaving, the administrator had provided training for staff including during the induction programme, in addition to providing advice to staff and ensuring the smooth running of the mental health review tribunals and internal appeals process.

All detention papers were received and checked by the hospital's Mental Health Act team. All detention papers that we reviewed during this inspection were present and correct.

Clinical notes documented the fact patients' rights were explained to them, which patients confirmed was done regularly. We saw documented evidence that showed that when patients were thought not to have understood their rights, staff explained rights to them again at another time. Copies of 'consent to treatment' authorisation forms were stored with medication charts. Section 17 leave decisions were documented. We reviewed Section 17 leave for a sample of the detained patients. Leave was authorised by the responsible clinician and recorded accordingly on the electronic system. This would be done upon assessment and review by the multidisciplinary team.

Patients spoke positively about the advocacy provision at the service. An independent mental health advocate was available on site when required, and held drop in sessions and meetings on site. Patients could ask for advocacy representation or staff could make a referral on their behalf.

There were information posters on advocacy and the Mental Health Act throughout the hospital. On some wards this information was displayed on overcrowded notice boards.

Good practice in applying the MCA

Staff knowledge about the core principles of the Mental Capacity Act was generally satisfactory and all knew where to seek further information. Training for all staff on the principles of the Mental Capacity Act was covered during induction and was available as an online module for those wanting more information. Nursing staff received annual refresher training. Healthcare assistants had varied understanding of the Mental Capacity Act, but were aware they could speak to charge nurses, and direct patients to the independent mental health advocate for information. Some assistants felt they would benefit from more specific training for their roles. All patients at the service were detained under the Mental Health Act, so there was no use of Deprivation of Liberty Safeguards.. We found evidence within case notes of second opinion approved doctor referrals being made and best interest meetings having taken place. We also found evidence of advance statements of patients' wishes and decisions.

Furthermore the service proactively interacted with the independent mental capacity advocate, making contact with the advocate when patients did not understand their rights but also if seclusion was required. On the psychiatric intensive care unit, staff would also email the advocacy service when they had a new referral.

Are forensic inpatient/secure wards caring?

Outstanding ☆

Kindness, dignity, respect and support

The inspection team were impressed by the respect and value placed on individualism of patients within this service, demonstrated by the many positive and respectful interactions we witnessed. Patients gave universally positive feedback about the staff. Staff and patients alike spoke positively about the senior management team and about their experiences of how service was managed.

Good

Forensic inpatient/secure wards

The balance between encouraging and developing independence whilst maintaining the security expected of a forensic service seemed to be well managed with positive risk taking and relational security used in appropriate measure.

Staff respected individuals' rights to privacy and dignity by respecting their rights to choose and decide even when the decisions being made were not always deemed to be the 'right' ones. Furthermore staff respected patients' rights to their own space, by entering their room if patient permission was given. Staff sought consent for randomised person and room searches.

There was a strong, visible person-centred culture across the service. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff across the service knew patients well, showing they had good understanding of all the patients in their care.

Relationships between patients, those close to them and staff were equally strong, caring and supportive as demonstrated by the four families and carers we spoke with. These relationships were valued by the staff and promoted by the senior managers. This included facilitating a carers' network to support carers including bringing them together for events and meetings where they shared their experiences and were able to sign post those needing support and advice accordingly.

Patients reported staff being available to speak to them when they needed them, including their named nurse. Patients spoke positively of the de-escalation process staff used. Staff were described as friendly, approachable, always polite and respectful even when patients had been restrained and were in seclusion. During this inspection, many positive and caring interactions between staff and patients were witnessed as staff demonstrated patient centred care.

The involvement of people in the care they receive

During our meeting with representatives of the patients council, patients spoke positively about their participation and work the council had done to date and mentioned they strongly felt that their voices were heard. This included initiating woodwork as a paid role, which saw patients using their creative skills to manufacture items that were needed ordered such as tables. Other issues discussed included the use of mobiles phones, problems experienced by patients using the electronic care record system and patients feedback on meal provision.

Care delivery was seen as a partnership between patients and the multidisciplinary team with them actively involved in care planning and risk assessments. This was also evidenced by their continued contribution of patients during their reviews, which included capturing this information within their own sections of the electronic care planning record that included their pathway to recovery.

Staff were encouraging and supportive as they attempted to empower patients to have a voice and to realise their potential. This included encouraging patient participation in activities and participating in the patient council

Continually during our conversations, patients spoke highly of the opportunities available for greater patient involvement. As part of the inspection process we heard from carers, patients and representatives from different staff groups. This included a presentation, which saw patients, staff, service leads and the service director come together to deliver an overview of the service with their key achievements and highlights, strengths and focus points. Empowering and supporting patients and carers formed the key themes of the presentation. Patients were actively involved as partners in community projects through paid work initiatives in the community, including art projects for a local resource centre.

During the presentation and throughout the visit we heard about the opportunities patients had to contribute to developing the service and ensure provisions available made a real difference to those using them. This included patients contributing to the service's governance committee and associated processes through engagement of the patient's council, which met on a monthly basis and brought representation from across the service. This gave the patients an opportunity to raise their concerns and affect meaningful change. Issues raised were then discussed at the service governance meeting, before being cascaded across the service, in individual wards in their community meetings. The council had opportunities to instil real change and development and this was supported by the service by ensuring there was budget available to implement suggestions when needed.

Good

Forensic inpatient/secure wards

Within each ward, patients engaged in community meetings as evidenced by the minutes and the two meetings we observed. These were held fortnightly on each ward and wherever possible a patient would chair these, and in doing so further develop their personal skills and rehabilitation. Meetings gave patients an opportunity to raise concerns about the ward with staff and managers present. It gave all patients the opportunity to discuss any issues they may have and seek reassurance or escalation accordingly. During the meetings, we witnessed staff responding positively when presented with rising emotions and challenging behaviour, bringing discussions back to a constructive dialogue. There were discussions regarding activities and events, updates were given about the ward and information about the service including policies were discussed. There was an opportunity to discuss relationships and interpersonal issues. Meeting minutes were taken and these minutes would be fed into the patient's council and then the service governance group.

Patient engagement was also evident when it came to planning new service provisions and staff recruitment. The new ward, the Coppice, had been designed and developed with patients contributing their thoughts and ideas directly into the development committee from the infancy of the project to construction and opening over the coming weeks.

Representatives from the patient's council and carers' forum attended the service governance group, ensuring the voice of patients and carers was heard at all levels. Minutes from a recent meeting captured the conversation and consideration of changes and illustrated the contribution of patients and carers to these meetings.

Upon completion of training in interview techniques, patients could participate in shortlisting and interviewing of new staff, as patient representation was present on the panel for recruitment interviews.

Other opportunities for patients to be involved in their care were the multidisciplinary team meetings, ward rounds and the care programme approach meetings. In all of these the patients were at the centre of the discussions being held. In case of care programme approach patients said they could chair their own meetings, and were involved in the planning of these, choosing who to invite which could include carers, family members and/or friends.

The service had been active in developing resources and information available for carers. This included the Carers Charter, the development of which was led by the cares forum and supported by the lead social worker for the service.

The service also held annual patient satisfaction and carer's surveys.

All wards had a payphone and the availability of facilities to allow patients to skype friends and family members from a private, quiet room.

Patients were positive about the advocacy provision and how accessible this was. An independent mental health advocate was available on site to see patients either by appointment or during drop in sessions. Patients could self-refer for advocacy or staff could contact on their behalf

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

Outstanding ☆

Access and discharge

The service had provision for 93 patients, with bed occupancy during our inspection at 97%. The service offered forensic and psychiatric intensive care provision, with low and medium secure wards, which had covered a national catchment. All the forensic wards accommodated planned admissions by referral whilst the psychiatric intensive care facility was intended for emergency admissions. Referrals were reviewed and assessed by ward managers and representatives from the multidisciplinary team completed the assessment. They would then present this information to the senior handover meeting, during which a decision would be made regarding admission based on the patient needs and the dynamics of the current caseload. Managed patient transfers between wards would be facilitated as a patient progressed along their recovery journey. There were dedicated pathways for moving from medium to low secure wards.

Following changes in provider, the service had been updating their welcome packs, though this was available on one ward, the low secure Lever ward. It gave a

comprehensive overview about the service and ward, including the ward philosophy, the care and treatment team, and the advocacy service. This Information would be provided to all new patients.

Over the last months there had been two delayed discharges from the service, patients from Hesketh and Hulton wards respectively. These had occurred due to difficulties in identifying a suitable placement for patients to be discharged to

The facilities promote recovery, comfort, dignity and confidentiality

During our visit, the inspection team, observed services which were tailored to meet the individual needs of patients. We saw educational and vocational opportunities which were delivered flexibly, given the constraints of a secure environment. There was continued involvement of other organisations and the local community in planning meaningful opportunities for patients and ensuring that the service met people's needs.

There was evidence of effective local community partnership working as we heard about some of the visits the patients had been on and the art project, which they had been involved with in partnership with a community centre. Working with different communities, the patients had participated in meaningful projects commemorating local history and heritage as well as supporting other vulnerable groups. Two such examples, saw patients participate in the collieries project, whereby patients created art including a pit wagon commemorating the rich and diverse experiences of a former collieries community. In another, patients painted the hall of a centre helping care for dementia patients, creating a reminiscence street. This helped visualise the past and so comforted the service users at the centre.

There was access to education, with courses offered in literacy and numeracy. On an individual basis, learning that was more specific could be planned and this included distance learning and open university programmes. The service responded proactively to the needs of some of the patients, having seen the therapeutic effect animals and nature had on them. Working in collaboration with therapists and psychology colleagues they tailored therapy sessions to benefit those patients by ensuring their respective wards had weekly access to two 'pets for therapy.' This included a pet dog which was regularly brought on site which patients helped look after and take for walks within the extensive grounds. On Hindsford ward patients also benefitted from the ward cockatoo. We heard the decision to acquire the cockatoo had been made some time ago by the patients.

The service facilitated individual preference for the outdoors. There was provision of outside space and outdoor activities for patients on each ward, with set access during the day subject to approval and supervision. Patients could request additional time outside. There was a running track for use by patients within the secure perimeter and vast woodland around the site, which were often used for group walks. Within the grounds there was also a lake, which was often used for freshwater fishing and there were allotments. Within the main hospital building, there were facilities for the provision of a vast array of varied activities, including a gymnasium, swimming pool, sports hall, art rooms, social room, photography suite and music studio. Some patients on Hindsford ward and Milford ward, where patients were deemed to be most well, were able to access regular home leave, which they talked positively about.

Opportunities to help improve access to employment for patients were also available in the form of short term internal job opportunities. These included shop assistant roles within the service shop, woodwork posts, painting and decorating, gardening and food serving within the kitchens.

Activities were available in the evenings and at weekends, with occupational therapy staff

available some weekends. The provision of structured and scheduled activities on Fridays, Saturdays and Sundays was nurse led. Communal activity provision included games tournaments, cinema club and use of the sports hall for team sports. Provisions for patients in the psychiatric intensive care unit, Hulton ward, included sessions led by occupational therapy in mindfulness and relaxation.

All planned activities were available by self-referral and were offered at various times of the week to suit patients. Staff said the primary objective of these activities was to help patients rediscover their existing skillset whilst maintaining and developing their interests. Group therapy sessions were offered on an individual basis to best meet the needs of those patients it was identified did not respond positively or effectively in group sessions.

The wards facilitated recovery and had a range of resources available to promote this. Each ward had a quiet room, a lounge for watching TV and a lounge for recreational activities, and a kitchen where snacks, hot and cold drinks provision were available for patients, which could be used at any time. Rehabilitation kitchens were also present on all wards for cooking classes after appropriate risk assessments had been undertaken. On each ward, there were areas available where staff and patients could speak privately. Patients were allowed access to mobile phones provided they had appropriate risk assessments in place and had approval from the multi disciplinary team or their responsible clinician. However, smartphones were not used as It was a requirement that phones did not have internet access. The wards did provide internet access under supervision if this was required. A payphone could be found on all wards within a room to ensure patients had privacy. We were told by some patients that the payphones did not seem consistent and there was concern about their charging. This had been escalated after being raised in community meetings. The warmth and humidity of all the wards felt appropriate.

The bedrooms we saw were spacious with inbuilt storage provided which included cupboards, wardrobes and television cabinets. All rooms had at least a sink unit. On some wards bedrooms had en suite bathroom facilities and those without had access to a shower and toilet facilities on each corridor, which were normally shared between four and six rooms. Patients were allowed to personalise their rooms and we saw evidence of this with photographs and posters amongst other individual possessions present in the rooms. Some patients had game consoles and televisions in their bedrooms.

Lockers were available for restricted items such as deodorants and aftershaves and razors, which could then be accessed under supervision. Most patients had keys to their own bedrooms and this was individually risk assessed.

There were visiting rooms available on each ward. Most of these were off the main ward area, near the entrance to the ward, which provided a more private and appropriate environment for visits. A separate family visiting room was available for visits by children, which would be individually risk assessed and required approval from the multidisciplinary team. All wards had access to facilities for video calls using skype, which were situated in a quiet room to allow for communication with family and friends who were not able to visit regularly or who lived further afield.

Most patients spoke highly about the food provision, which we observed and which seemed of a high standard and generally of good portion size. Some patients commented about the lack of consistency in portion sizes and this was something that had also been fed back through the community meetings. A number of meal options were available including low fat meal and diet specific options. The same food options were also available for staff across the service. On the wards, staff would sit and eat with patients, creating a sense of family meal times.

Meeting the needs of all people who use the service

Some patients required appropriate access modifications due to their reduced mobility. We found that there were reasonable adjustments made for them and people living with a disability. This included the provision of a ramp to use instead of stairs, accessible toilets, and a wet room on Milford ward. Furthermore the service had in the months preceding the inspection, admitted a patient with complex care needs, such that the service had not catered for previously. To adapt to his needs the service had redesigned and modified the ward environment to make it more appropriate for him.

Patients could access wards with some provided on the ground floor and wards that had bedrooms on upper floors were accessible by lift if required.

Information was available in other languages if needed including in leaflet and audio format. The service had access to an interpreter service if required.

The catering team were able to provide for every need upon request, including accommodating for specific religious and ethnic groups. The chef was available on request to discuss more specific requirements.

Patients had access to spiritual support and were able to access religious services, within the multi faith room on the main site if they required it. An imam and a minister visited regularly and by request.

Listening to and learning from concerns and complaints

Good

Forensic inpatient/secure wards

Patients we spoke to said they were aware of how to complain and felt the service would listen to their concerns. The complaints process was outlined on posters and information provided in welcome packs. Over the 12 month period, July 2016 to June 2017, there were seven formal complaints across the service of which two were upheld. All complaints were resolved internally. No complaints were referred to the Parliamentary and Health Service Ombudsman. Additionally complaints could be made informally within the wards if patient were happy for a local informal resolution by the ward manager. Ward staff recorded these complaints, which often were verbal complaints, on each ward and there was an emphasis to resolve these on a local level. Formal complaints were investigated by the complaints officer and findings shared through lessons learned and regular audits of complaints across the service.

The well-structured complaints file was reviewed during our inspection. It evidenced the proper investigations held into formal complaints and capturing of details about informal complaints. It showed evidence of actions taken when complaints were upheld including apologies and financial remunerations. These complaints varied in nature from complaints regarding cancelling of leave to objections to randomised searches. There were other complaints regarding other patients, activity provision and items missing. The file also detailed the recommendations made following investigations. However the complaints policy and complaint outcome letters did not explain the role of the CQC regarding complaints relating to the Mental Health Act

Are forensic inpatient/secure wards well-led?

Outstanding ☆

Vision and values

Since October 2016, the Spinney had been managed by Elysium Healthcare Ltd and as a result, the corporate vision and values had been updated to reflect this. The core values were:

- Innovation
- Empowerment
- Collaboration
- Integrity
- Compassion

The core service objective was to make a real difference by encouraging hope and optimisation, through complete care pathways. The awareness of the values amongst the staff body seemed to vary considerably, though there was a general understanding of the objective of the service.

Individual members of staff we spoke with stated they felt valued and supported by the service and enjoyed their work at the service.

We witnessed these values in action throughout our inspection. There was a general sense of compassion towards all the patients, carers and colleagues as staff acted with integrity in the work they undertook, genuinely caring for those around them as staff collaborated with each other and patients to deliver patient centred care. There was a focus on empowering patients and encouraging independence, through a combination of positive risk taking and diversifying their interests by offering a wide array of activities and therapies to facilitate their recovery.

Good governance

There was evidence of good governance processes, underpinning how the service was run with regular audits and monitoring. Roles and responsibilities were well defined in line with the corporate policy. This ranged from ensuring staffing levels were appropriate and safe to listening to all involved in the service. Governance appeared to be an integral part of the planning and decision making undertaken at the service.

There was evidence of meetings at different levels across the service being held regularly which all fed into the governance group. This included community meetings held on individual wards during which patients aired their concerns, team meetings, patient council, carer's forum and senior team handover.

There was a strong emphasis on governance from the ward to the board which incorporated the service's desire to be solution focused, concentrating on recovery and rehabilitation. The governance group, which had representation from across the service, met quarterly.

On the wards, there were opportunities for patients to partake in governance activities with the ward 'quality matters' initiative engaging patients' views as well as those

of staff. Ward managers had access to a range of electronic governance tools including dashboards, which visually presented information in real time, regarding training, care planning, risks, leave, incidents and complaints. Additionally audits were also done across the service, reviewing various key aspects of the service including staffing, health and safety, risk assessments and use of high dose anti-psychotics.

Governance processes for the service were overseen by the provider, who carried out regular compliance visits and reviewed governance through monthly meetings to monitor quality assurance.

Daily handover meetings between the senior managers, medical and clinical staff ensured there was good oversight of current issues and concerns affecting the service and individual patient care. Current and immediate staffing needs were reviewed, allowing for appropriate actions to be taken if additional resources were to be needed. Staff who partook in these meetings described these as being structured and informative, allowing for constructive and productive dialogue regarding pending issues on each ward.

Individual ward managers felt they had the authority required to do their jobs and all felt supported by the management team and other colleagues. One of the managers we spoke to, who was covering the role on a fixed term basis, was impressed at the support she had received. Ward managers would meet with charge nurses on a weekly basis to carry out various reviews including looking at completion of physical observations, assessment and care plan completion and whether patients have been offered their care plans. .

We did see good use of innovation and technology to help deliver care and cater for patients' needs, including the use of video conferencing facilities to allow patients to contact their families or care programme approach co-ordinators, both of whom could be located some distance away, given the national catchment of the patients present.

The governance group took representation from all parts of the service including staff, patients and carers. Patients felt they could make suggestions and these would be looked into. Members of the patient council told us that the service would always look at suggestions and there was an ethos of looking at how things could be done and not how they could not.

Senior leaders we spoke with appeared to have a rounded awareness of the key issues and concerns across the service and those affecting individual patients. Staff spoke positively about the service director, the clinical director and the nursing director who all had an oversight of current governance priorities across the site.

Integral to the governance processes at the service was the culture of continuous learning and development, which was attempted after each incident. This learning would then be shared across the service and beyond. However awareness amongst staff and ward managers of the service's risk register and how to submit items to it varied.

Leadership, morale and staff engagement

Staff knew who senior managers were and the senior management team often visited the wards. Staff felt part of a wider team and felt their opinions mattered. This gave individuals the sense they had a voice, which would be heard across the multidisciplinary team.

Staff across the service at different designation and grades, reported feeling valued and supported by their immediate line managers but also by the service. The overwhelming consensus from the staff was positive and they felt valued and said that morale was very good. The approach to staff engagement, recruitment and retention had received national recognition from the Nursing and Midwifery Council who had invited the staff engagement lead to their conferences to speak about the service's approach. There were various staff incentives in place, including additional leave on birthdays, staff discount scheme, relaxation days, free meals whilst on duty, access to a gym and childcare vouchers. There was also recognition of staff contribution, with various opportunities for accolades and acknowledgments throughout the year, to make individuals feel appreciated.

Continuous development was supported across the organisation, with protected learning time and funded courses to help staff develop and reach their full potential. Through the appraisal process and training needs analysis, senior nurses had opportunities to partake in various training and courses including leadership and management training.

Staff sickness varied across the disciplines present at the service. For the 12 month period to July 2017, sickness rates were all low; housekeeping had the highest sickness rate with 4.4%, administrative staff had 3.8%, nursing staff

had 2.5% sickness rate and psychology staff had a sickness rate of 1.1%. Staffing provision across the service was over the intended numbers, to allow the service flexibility and enable better coverage when needed. The disciplines with the most staff leavers over the same period were catering with a 22% leaver rate, social work with a 20.8% leaver rate and nursing with a 10.3 leaver rate.

The service embraced feedback and adopted a culture of honesty and learning from experiences at the service and beyond. Staff received regular updates in team meetings, handovers and through electronic publications. Posters advertised a mechanism for reporting any concerns and staff told us they felt the management team were approachable if they needed to raise concerns. The service director had an open door policy which the other senior team were also encouraged to follow, allowing staff to visit and discuss with them any concerns or offer feedback at any time.

Commitment to quality improvement and innovation

The service utilised information technology to compliment processes intended to decrease its dependence on paper records further by utilising electronic information and presenting this as dashboards. The dashboards utilised Information captured in care records, which was readily available in terms of clinical notes, assessment tools and care plans and Mental Health Act documentation, so that it could be reviewed together for all the service. This highlighted any areas of concerns, for examples that physical health checks or risk assessments were overdue. Handovers, multidisciplinary team meetings and ward rounds used technology to input and update patient care records immediately, ensuring real time information was always available. Information from patients' electronic care notes then pulled through specific data items into the ward dashboard. For example, on a daily basis, staff recorded uptake of each patients planned activities. This then populated data on the ward dashboard to show whether patients were receiving 25 hours or more of meaningful activities. Likewise patients could input their own entries onto Pathnav, the providers bespoke electronic clinical tool and record system.

The service demonstrated a clear commitment to improvement and innovation. Patient involvement and engagement in the service was a continual process and was driven by service users and supported by the staff team. The service had also developed links and working with families and friends of patients by developing a carers' forum. Patients also participated in induction of new staff and help in delivering training about recovery. Furthermore there were opportunities for patients to develop their own skills by enrolling onto education and training courses or joining the preceptorship academy to present to others their experiences and individual journey.

The service used a range of tools and methodologies that it had integrated into its care plans and pathways, to ensure best practice was followed by all. The forensic service was accredited in the quality network review accreditation scheme overseen by the Royal College of Psychiatrists. The staff at the psychiatric intensive care unit were involved in the national association of psychiatric intensive care units meetings and had started to benchmark the service against national standards with a view to becoming accredited.

Outstanding practice and areas for improvement

Outstanding practice

Throughout our inspection we found evidence of the service striving to go above and beyond for patients, carers and staff.

The focus on recovery was supported through a comprehensive therapeutic programme which utilised a variety of facilities such as a swimming pool and a gymnasium. The service offered a diverse activity programme supported by its occupational therapy team seven days a week. There was an emphasis on developing and rekindling skills and interests by having a diverse array of activities and courses available for patients on the hospital site and within the community.

Training was seen as an opportunity to develop patient skills for life beyond their stay in hospital and was reinforced through the provision of courses but also a variety of work experience placements. Patients had an opportunity to work in different hospital departments, from the kitchens and joinery workshop to the shop, all in an effort to develop their experiences and confidence.

Patients were also offered real work opportunities through meaningful external experiences for which the service utilised links with other organisations including community partnerships to offer patients real life experiences. This included the collieries project, whereby patients created art including a pit wagon commemorating the rich and diverse experiences of a former collieries community. This paid tribute to the collieries past and was used to support a centre for people with dementia, where the patients from the service had painted a reminiscence street. There were also good links with sports organisations which the patients visited and helped with on different projects.

The service recognised the importance of promoting carer involvement in a variety of ways including utilising technology to help patients stay in contact with loved ones, using skype and video conferencing and offering a pickup service available to collect visitors from local mainline train stations and bus terminus. The service also supported a fully functional and active carers' forum which it had supported to help develop a carers charter to clearly provide the rights carers could expect from staff and managers at The Spinney.

Areas for improvement

Action the provider MUST take to improve

- The service Must ensure all Ligature cutting equipment is securely and appropriately stored where it cannot be accessed by patients

Action the provider SHOULD take to improve

- The service should routinely reassess ligature risks, to identify new risks such as the unrestricted electrical cords on Lever ward.
- The provider should consider the need to improve the pathways to the Coppice to improve any required emergency response from staff from the main building at all times.
- The provider should make sure that in the future references of new starters should be fully checked and verified along with relevant risk assessments when a member of staff or volunteer has previous convictions.
- The service should ensure paper notes and records are always dated even if the same information is captured electronically.
- The provider should ensure that the complaints policy and complaints outcome letters refer to the role that the Care Quality Commission has in considering complaints relating to the powers and duties of the Mental Health Act.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ligature Cutters were attached to a notice board within a staff office on a medium secure unit, which patients did enter at times. This was a breach of: Regulation 12e: ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way.