Requires improvement

Cheshire and Wirral Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXA72	Soss Moss	Alderley Unit	SK10 4SZ
RXA72	Soss Moss	Saddlebridge Recovery Centre	SK10 4SZ

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated low-secure forensic inpatient services for working age adults as requires improvement because:

- Staff failed to follow the Mental Health Act code of practice or the Cheshire and Wirral NHS Partnership Foundation Trust policy in relation to seclusion and segregation. One patient had been cared for in seclusion for eight days. Records did not demonstrate the need for the patient to be nursed in seclusion for this extended period of time.
- Staff working on the units were not aware of the high-risk ligature points identified in the trust annual ligature audit undertaken in July 2014.
- There were additional ligature risks and a number of multiple blind spots throughout both units, which could have compromised the safety of patients, visitors and staff.
- There were blanket restrictions in place and patients told us that rules changed day to day, depending upon which staff were on duty.
- Patients told us that activities and planned leave had been cancelled due to staff shortages.
- The vision and values of the trust were not demonstrated by all members of the staff. This could be seen in complaints about staff attitudes and behaviour.
- Managers had failed to identify concerns regarding the use of seclusion, the standard of recording in the clinical records when seclusion had been implemented and the recording of incidents.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff failed to follow the Mental Health Act code of practice or the Cheshire and Wirral NHS Partnership Foundation Trust policy in relation to seclusion and segregation. One patient had been cared for in seclusion for eight days. Records did not demonstrate the need for the patient to be nursed in seclusion for this extended period of time.
- Staff working on the units were not aware of all the high-risk ligature points that had been identified in the Cheshire and Wirral NHS Partnership Foundation Trust ligature audit undertaken in July 2014.? There were multiple blind spots throughout both units, which could have compromised the safety of patients, visitors and staff.
- Patients and staff told us that there were different rules in place depending upon who was on duty. This meant that, what patients were allowed to do changed depending on who was on duty. For example, a staff member said sometimes patients would not be allowed to eat a sandwich with their soup. However, on other days this would be allowed.
- Saddlebridge Recovery Centre had introduced a blanket restriction associated with soft drinks, crisps and chocolate bars. Staff told us this was in line with attempts to support healthy eating and physical well-being and that these arrangements had been agreed in meetings with patients. Patients told us they were not happy that they were being restricted from buying the types of food and drink that they would prefer.
- Staffing was below required levels and patients told us that activities were being cancelled due to staff shortages.
- Staff were not reporting all incidents of seclusion on the trust's electronic incident recording system, despite staff being aware that this was required.
- Staff were not keeping accurate records of the temperature of the fridge and freezer in the rehabilitation kitchen in the Saddlebridge Recovery Centre. This issue had been raised at the staff team meeting in February 2015.

However,

- Both units were built and furnished to a high standard and were visibly clean. Patient bedrooms were spacious and well

Summary of findings

equipped, with en-suite facilities. Patients were actively encouraged to personalise their rooms and had access to personal belongings. There was access to a large, peaceful outdoor area and a family visiting area located off the ward.

- Both units had consistent security arrangements in place to ensure the safety of patients, staff and visitors. These were appropriate for a low-secure inpatient facility and there were good systems for overseeing these. Patients had detailed risk assessments in place and clear plans to reduce identified risks, while still enabling them to spend time undertaking rehabilitation activities outside of the units.

Are services effective?

Good

We rated effective as good because:

- There was access to the full range of evidence-based interventions appropriate to meet the needs of the patients using these services, which included nursing, occupational therapy, psychiatry and psychological interventions.
- Both units were part of the National Secure Services Quality Improvement Productivity and Prevention Programme and many of the key recommendations and requirements were in place. The Quality Network for Forensic Mental Health had undertaken a recent peer review and there were significant improvements recognised within the Saddlebridge Recovery Centre.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Two patients on Saddlebridge Recovery Centre told us, 'sometimes the staff can joke about stuff that can be offensive' and 'staff attitude is sometimes not very good.'
- A patient from the Alderley Unit with stated, 'there have been one or two staff who have not treated me with dignity and respect.'
- One person on Saddlebridge told us that patients were afraid to make any written comments as they worried that staff on the unit would read the comments. Their fears were confirmed when the trust reviewed closed circuit television footage.

However,

- There was also some good feedback, especially on the Alderley Unit, and patients were keen to point out that not all staff were lacking in respect.

Summary of findings

- When we told the trust about the negative feedback, they immediately looked into the complaints and began their own investigation into the concerns raised by patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were comprehensive activity plans in place demonstrating attempts to provide flexibility and choice in the range of activities patients could engage in.
- The facilities and premises were in good decorative order and appeared designed to meet the needs of the patient group.
- Discharge planning commenced shortly after admission. There were no delayed discharges and no waiting lists for admission.
- There was evidence that action had been taken to resolve complaints made.

However,

- The activity attendance sheets in place on the unit were not regularly completed. This made it impossible to determine if planned group sessions happened or not.
- Patients stated activities were regularly cancelled due to staff shortages and it was not possible to identify how often this occurred.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The vision and values of the trust were not demonstrated by all members of the staff. This was seen in complaints about staff attitudes and concerns about practices, such as blanket restrictions and inappropriate seclusion.
- Standards and quality were not being routinely monitored, such as the trust ligature risk assessment and its subsequent management plan, and the requirements to improve identified in the Mental Health Act review report 5 June 2015 had not been communicated to the Saddlebridge Recovery Centre team manager who was not on duty during the visit.
- Ligature risks and blind spots that had not been recognised by the trust were identified during the inspection.

However

- There were new additions to the senior staff on the ward on Saddlebridge Recovery Centre and there had not been sufficient time for the impact of their leadership and interventions to be fully apparent.

Summary of findings

- It was noted that there had been improvements in the numbers of staff receiving line management supervision.

Summary of findings

Information about the service

Cheshire and Wirral Partnership NHS Foundation Trust provide low-secure forensic services at two units, Alderley Unit and the Saddlebridge Recovery Centre. These are both based in Cheshire East at the Soss Moss site. All admissions into these units are managed by the North West Specialist Commissioning Team (NWSCT).

Alderley Unit accommodates adults aged from 18 years who have mild to moderate learning disabilities. It is a new purpose-built unit. Saddlebridge Recovery Centre is an adult inpatient unit for individuals experiencing enduring mental health issues. Both have 15 beds and are for males only. All of the inpatients were detained under the Mental Health Act 1983.

York House was a building on the same site where therapeutic activities took place. We did not visit York house as part of this inspection. There was a team of occupational therapists who worked with patients on both of the units and oversaw the activities at York House.

A senior psychologist worked across both units and a senior social worker who was the unit lead for safeguarding. The social worker also had an additional key role in supporting people as they were preparing to be discharged from these units. The services work closely with the NWSCT throughout the inpatient care episode.

The Alderley Unit moved to its current building three months before this inspection. It had been on the same site at Soss Moss but in a much older building. The Care Quality Commission (CQC) inspected the older building in March 2012. There were no compliance actions to address following that inspection.

The CQC had not previously inspected the Saddlebridge Recovery Centre. However, there had been a Mental Health Act review on both units; Alderley Unit on 18 June 2014 and Saddlebridge Recovery Centre on 5 June 2015.

Alderley Unit had a number of discharges leading up to the closure of the old building and at the time of our inspection there were seven patients on the ward and another four due to be admitted in the following weeks.

In July 2014, there had been a major incident on the Saddlebridge Recovery Centre. This had resulted in all of the patients being moved to alternative secure facilities and the staff redeployed within the trust. Saddlebridge recovery centre was closed for an investigation into what had happened and for refurbishment. This had concluded by late-November and in December 2014 the unit reopened to admissions. At the time of the inspection, there were 11 patients on the ward, five of whom had been admitted there previously.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director Mental Health at Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (mental health), Care Quality Commission,

Simon Regan, Inspection Manager (community health services), Care Quality Commission.

The team included two CQC inspection managers, three CQC inspectors, five specialist advisors from nursing, psychology and social work backgrounds, a Mental Health Act reviewer, an expert by experience, a consultant psychiatrist and a CQC pharmacist.

Why we carried out this inspection

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

Summary of findings

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?

Prior to the inspection, we reviewed a range of detailed information made available by the trust including policies, minutes of meetings and evaluation reports. CQC hosted focus groups seeking the views of people who use Cheshire and Wirral Partnership services, their carers and staff.

During the inspection the team:

- visited the two low-secure forensic inpatient units based at the Soss Moss site: the Alderley Unit and the Saddlebridge Recovery Centre;
- spoke with six patients;
- spoke with two inpatient service managers;
- spoke with one resource manager;
- spoke with four nurses;
- spoke with five clinical support workers;
- spoke with two medical staff;
- spoke to the safeguarding lead/social worker;
- spoke to two occupational therapists;
- spoke to one consultant psychologist;
- observed one multidisciplinary meeting;
- observed one community meeting;
- observed one medication round.

The team reviewed:

- seclusion paperwork for two episodes of seclusion;
- ten electronic care records;
- five Mental Health Act section 17 leave documents and the associated individual intervention plans;
- nineteen prescription charts and 11 T2 (certificate of consent to treatment) and T3 (certificate of second opinion) certificates , which showed evidence of consent to treatment and that a second medical opinion has been sought;
- staff rotas for both units;
- the completed Mental Health Act review report for Saddlebridge Recovery Centre (dated 5 June 2015);
- a range of policies, procedures and other documents relating to seclusion and segregation;
- copies of team meetings on Saddlebridge Recovery Centre;
- copies of "My Service My Say" minutes;
- copies of completed mandatory training by Saddlebridge Recovery Centre and Alderley Unit;
- confirmation of line management and appraisal undertaken on Saddlebridge Recovery Centre and Alderley Unit.

What people who use the provider's services say

The CQC undertakes meetings with people who receive services from and work in the trust services before inspections. People can complete comment cards, which are distributed across services. These are placed into sealed boxes and people can leave anonymous comments if they wish. There were two comment cards left within the boxes placed on the units. The CQC promotes access to its national call service to leave feedback via the 'my experience' facility. During the inspection, the CQC team meet with patients to ask them directly about their experience of receiving care from the ward.

Patients provided the following feedback when we met with them during the inspection:

- They felt that Saddlebridge Recovery Centre was too restrictive and it felt more like a prison than a hospital ward.
- Some of the patients we spoke to made us aware they were not happy with the restrictions in the number of clothes they could keep in their rooms or the amount of foods and drinks of their choice that they could have.

Summary of findings

- Two patients told us they were unhappy about the attitude of some of the staff on Saddlebridge Recovery Centre and that they sometimes joke about things that could be offensive.

However, this was not the only feedback. Some was positive about staff at both Alderley Unit and Saddlebridge Recovery Centre. Patients described being treated in a way that was respectful and that staff were caring.

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to improve

- The trust must ensure that patients are cared for in the least restrictive manner and review blanket restrictions in place.
- The trust must ensure that patients are cared for in seclusion in line with the MHA Code of Practice
- The trust must ensure that staff are aware of environmental risks and that actions are taken to mitigate these as far as possible
- The trust must ensure that patients are always treated with dignity and respect
- The trust must ensure that there are sufficient, suitably skilled staff to meet the needs of patients
- The trust must ensure that the governance arrangements are sufficiently robust to effectively monitor the quality of care being provided

Cheshire and Wirral Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Alderley Unit	Soss Moss
Saddlebridge Recovery Centre	Soss Moss

Mental Health Act responsibilities

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

When we reviewed the MHA documentation at both inpatient areas, we found evidence that people were being informed of their rights and that the patients we spoke to confirmed they understood their rights under the MHA. Two patients said they would prefer information in an easier to read format, so they could better understand what leave they were able to have.

There were improvements in the completion of documents about people's consent to the treatment they were receiving and the correct forms were in place alongside medication charts.

An MHA reviewer had attended Saddlebridge Recovery Centre three weeks before this inspection. They had noted concern in a number of areas and had asked that the trust look to address those concerns. These included that some of the new rules about food and drink may be too restrictive, greater focus needed to be upon supporting the development of independent living skills, leave being cancelled due to staffing problems and concerns about the attitude of some staff. The trust were asked to provide an action plan to identify how these issues were to be rectified. This was submitted shortly after the inspection was undertaken.

The staff that we spoke to had a good understanding about the MHA and the trust provided staff with training that was appropriate to the job that they were doing. We saw that 83% of the staff had completed the mandatory MHA training, which is just below the trust target of 85%.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

When this inspection took place, all of the patients were detained under the Mental Health Act. The staff we spoke to understood the core principles of the Mental Capacity Act and the qualified staff that we asked could provide a brief overview of the Deprivation of Liberty Safeguards (DoLS).

The trust provided training in both of these areas. Eighty seven percent of staff had completed the mandatory training.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

We visited both low-secure forensic units during this inspection and there was an unannounced return visit to both on 6 July 2015.

Safe and clean environment

The units were spacious with high ceilings and an open plan layout. There were large windows and plenty of natural light. There was an airlock entry system from the reception area of the unit into the ward and an additional secure door separating the staff work areas and offices from the main ward. Each shift, a member of staff was allocated the responsibility of ensuring security systems were in place, including the allocation of keys and fully working personal alarms.

There were call alarm systems in each bedroom and throughout the unit. In addition, all staff and visitors were allocated a personal alarm and given clear instructions on its use. During the inspection, an alarm sounded in a bedroom and there was a rapid and efficient response to it by the staff. The two units provided additional staff responses to each other in the event of an incident. There was an emergency team based at the Macclesfield hospital site that could be called if there was a mental health crisis within either unit. In the event of any other emergency the units were required to call the emergency services.

Each ward had a central communal lounge, an open plan games area and a dining area. Ancillary rooms, such as a computer room, art room, gym, rehabilitation kitchen and laundry, and bedroom areas were accessed from the main space. CCTV covered the main ward areas but these were not routinely monitored. Bedrooms were spacious and had built-in furniture. Each had en-suite toilet and shower facilities. Patients had their own fobs so they could secure their rooms. Staff could override all locked doors and anti-barricade doors in place so staff could open doors either inwards or outwards in a crisis situation.

All patients had their own door fobs and were able to lock their rooms. There were no time restrictions for patients to access their rooms. Patients were encouraged to personalise their rooms and many had a television, posters and other decorations.

Staff confirmed that searches were undertaken. However, there were some inconsistent reports over how this was done, as some staff stated it occurred in the airlock and others stated it would not be undertaken within the airlock.

There were a number of restrictions in place on both units and some of the patients told us they were unhappy with these. These restrictions included the amount and type of clothes located in rooms and access to their own money. Staff stated this was part of the units' operational procedures.

A number of patients expressed dissatisfaction with restrictions on the types of snacks, fizzy drinks and foods that they were allowed to bring on to the unit. Patients were able to keep these snacks in their rooms or their lockers where staff would distribute them out on a daily basis. There was evidence that dissatisfaction with this rule were regularly raised in the My service, My say meetings.

Staff informed us that these restrictions had been implemented to support national physical health initiatives and commissioning for quality and innovation targets. This was relating to indicator 4 - Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness. This issue was discussed at the Physical Health Steering group meeting on 23 M ay 2014 where it was agreed to state what the maximum amount of the restrictions should be but to agree this on an individual basis with patients.

Some of the rules in place applied to all the patients and these appeared to be blanket restriction applied irrespective of an individual's needs. It was not clear if alternatives such as education sessions about healthy eating had been tried before the bans were imposed.

Staff discussed ways to encourage patients to engage in activities other than those involving food as a reward and

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this could be seen in the minutes from staff meetings. The minutes also indicate that staff were trying to use skills and strengths within the staff team to try to increase motivation within the patients.

Throughout both units plastic plates, cups and bowls were in use. Staff stated that patients were able to use personal china cups and mugs if they preferred, but for infection prevention and additional security reasons, staff preferred to make disposable and unbreakable mugs and cups available

All of the bedroom doors had adjustable window panels to enable observations to be undertaken. All of these were fully open on each bedroom door and afforded little privacy. There was no mechanism inside the patients' bedrooms to close these.

Where appropriate risk assessments had been completed patients had access to their own mobile phones including smartphones. These could be used whilst on section 17 leave and placed in the secure lockers on return to the unit. Patients were able to retain basic mobile phones in order to text and make calls on the ward and there were no additional restrictions to these. A payphone with appropriate privacy was also available located on the ward

When off the unit, patients could have access to their own smart phones, but, on return, these were placed in lockers located next to the airlock along with other items that were not allowed into the secure ward environment. Each locker was labelled to indicate whose belongings were in it and the nursing staff retained the keys. There were additional lockers within the ward environment, again labelled. These were for patients to have access to other restricted items, such as spray deodorant and aftershave, or personal razors. Staff had the keys to these lockers, but access was given on a daily basis.

All inpatient mental health wards are required to undertake a regular ligature risk audit. This is because there is a higher risk of patients using fixed points to attempt suicide. Cheshire and Wirral NHS Partnership Foundation Trust carried out these audits annually. The most recent was completed in July 2014. Both of these were carried out before the units were open to new admissions. There were alarm strips on top of the en-suite doors. These were tested daily and this was recorded. Staff were not aware that the unit ligature risk audit had detected additional ligature points rated as high risk in the panelling within patients' en-suite bathrooms.

There was unrestricted access to a large garden area with seating. Patients could use an inner garden, which was fenced off, under supervision. This contained trees, which were subject to protection orders and were considered a ligature risk. The inner garden was a focus for plant and vegetable growing and staff and patients worked together in achieving this. Three windows from the ward corridor opened into the garden area. When opened these exposed a steel bar which was part of the opening mechanism. We asked the trust to carry out an assessment and take necessary action to mitigate any risk to patients The garden had a number of blind spots if the staff were not directly supervising from outdoors. This was pointed out to the staff during the inspection. Managers decided to close the garden areas to unsupervised access with immediate effect and undertake further assessment to look at how to reduce these risks.

There were clear lines of vision from the nursing office into the main lounge and games room areas. Staff were deployed into the communal areas to undertake observations, for example into the lounge area or the dining room. Some staff were allocated to facilitate groups when they were in session in the kitchen, the computer room or the gym. However, there were multiple blind spots within both units. These were pointed out during the course of the inspection and we asked the trust to undertake further assessment to look at how to reduce these risks.

In order to support development and maintenance of rehabilitation skills relating to menu planning and cooking, both units had therapy kitchens, which were kept locked when not in use. They were well-equipped and operational procedures were in place to ensure safety under supervision of either the ward-based nursing staff or the occupational therapy staff. The kitchens were well-maintained and all utensils and cooking equipment were locked away in line with the unit operational procedures. The fridge and freezers contained food that the patients cooked during these sessions. At Saddlebridge Recovery

Requires improvement

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Centre, the temperature of the fridge had not been recorded on 20 occasions in June 2015 and the freezer on 14 occasions. This was pointed out to the staff during the inspection and the staff member agreed to rectify this.

The wards were clean and there were cleaning schedules for both areas, which had been completed. Patients told us that they cleaned their rooms about every two days and that the housekeepers assisted them with this. Patients on both units told us that when there are environmental problems that require repair, such as blocked toilets, these are usually dealt with in a couple of days.

Both units had a seclusion room, with en-suite shower facilities and an extra care area lounge with two chairs and a couch. These were weighted to prevent them being thrown. The rooms had high ceilings and flattened lighting. The seclusion rooms had an intercom. Staff were able to adjust the lighting, heating and ventilation in the seclusion rooms. There was a large clock and access to a secure garden area in each. There were large windows allowing natural light and fitted with security film, which meant people passing outside the unit could not see in. The suites were clean and neutrally decorated with a large mural on one wall.

Treatment and clinical rooms were clean and checks were up to date on required equipment. Staff knew where essential equipment, such as ligature cutters, was located. The fridge temperatures where medications were stored were regularly recorded. Fire checks were in place and there was evidence that fire equipment was tested regularly.

Safe staffing

Thirty-four percent of the nursing positions at Saddlebridge Recovery Centre were vacant for 12 months to March 2015. The majority of those posts had been recruited to, although not all staff were in post at the time of this inspection. These vacancies added to the staffing pressures on the Saddlebridge Recovery Centre of a staff sickness rate varying up 18% in the same time period. Patients told us that activities were cancelled when the ward was short staffed. By comparison, Alderley unit had an 8% staff vacancy and 10% sickness rate.

On Alderley unit, the number of staff on duty in the previous weeks appeared appropriate for the number of patients on the unit at that time. The staffing rota for Saddlebridge Recovery Centre was reviewed for the period 4 May 2015 to 28 June 2015 We found:

- The unit had operated below the required number of qualified staff on 27 of the 12- hour day shifts.
- On 18 of these occasions no additional unqualified staff had been employed to supplement the numbers on duty.
- On 33 occasions the unit had operated below the required number of qualified staff at night.
- On 15 of these occasions no additional unqualified staff had been employed to supplement the numbers on duty.
- There were high sickness levels with 25% sickness absence in Band 3 and 5 nursing staff.

Resource managers were responsible for maintaining the rotas and used e-Rostering. These rotas were created six weeks in advance. They were responsible for ensuring the right number of grades and skill mix were allocated to each shift as per their operational procedure as well as ensuring staff attended all required training.

Nursing staff on both units worked 12-hour shifts with a minimum requirement of two qualified nurses and four unqualified nurses during the day and two qualified and two unqualified nursing staff on each unit at night. As Alderley Unit had reduced numbers of patients, there was flexibility in the minimum staffing numbers. Ward managers were also on duty, but not included in the numbers working each shift.

On the second visit, the ward manager on Alderley Unit was not available as they had covered a shift on the previous weekend. There was one qualified nurse and an additional staff member on restricted duties. Staff stated the reduced numbers were due to staff sickness and ongoing vacancies. On the day of the return visit, escorted activities went ahead as planned as the occupational therapy staff assisted in providing the necessary cover.

The rotas were reviewed and the number of staff on duty on Alderley Unit appeared appropriate for the number of patients at that time and the range of escorted activities in place.

At the MHA review undertaken on 5 June 2015, patients stated that activities were cancelled due to the unit being

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short-staffed. Patients continued to state this during the inspection. Staff confirmed that where possible activities were postponed rather than cancelled. It was not possible to review how many instances of this had happened in the past six months as it had not been clearly recorded.

Mandatory training

Eighty five percent of the clinical staff at the Saddlebridge Recovery Centre had completed required mandatory training and 96% for the Alderley Unit. This was in line with the trust target of 85%.

Assessing and managing risk to patients and staff

Staff completed a clinical assessment of risks to self and others (CARSO) for each patient. This provided a summary of historical and current risks to the patient and others. The majority had a completed Historical Clinical Risk Management 20 (HCR-20). This structured tool measures against 20 key violence indicators; it supports clinical staff to explore possible future risks and formulate plans to reduce these. Three of these documents were reviewed and appeared to be comprehensive and of good quality. The electronic patient records communicated all documented risks in red font above open clinical records. This meant that anyone accessing the record could easily see the documented risks without accessing the completed risk assessments.

Patients had individual intervention plans completed which linked to activities and section 17 leave. The plans identified risks to be considered and actions to reduce those risks. They were contained in a folder alongside the section 17 leave records. Five of these plans were reviewed and they contained up to date risk assessments, which linked to the identified risks in the CARSO and HCR-20. They had all been signed by the patient except one. This ensured staff had access to the correct documentation and could review and implement the documented risk management plans prior to facilitating a patient's leave.

All patients were on hourly observations, unless on enhanced levels of observation. All staff were familiar with the observation policy. Observations were appropriately recorded and staff were clear who was responsible for undertaking these checks at all times.

Cheshire and Wirral Partnership NHS Foundation Trust had training available on the management of violence and aggression and 83% of clinical staff had completed mandatory managing violence and aggression training. Staff informed us that de-escalation was attempted in all instances and gave examples of some techniques that could be used.

There were arrangements for a local GP and a practice nurse to alternate attendance to the units on a fortnightly basis. In the clinical records reviewed, there was evidence of comprehensive physical health checks. These were undertaken on admission and annually thereafter.

A number of patients told us that they were not happy with the rules imposed around access to fizzy drinks, packets of crisps and chocolate bars. One patient stated they were unhappy as the unit commitment to healthy eating did not extend to the types of food patients were allowed to cook in the rehab kitchen. They also stated that staff did not have similar restrictions and on occasions were observed to be eating cake and drinking fizzy drinks in the staff office.

Managers stated that incidents of restraint were recorded on the electronic risk reporting system. The staff we asked confirmed that in the event a patient ended up in the prone position during a restraint attempts would be made to turn the patient immediately. Staff told us that restraint and rapid tranquilisation was not regularly used on either unit and there were three incidents of seclusion recorded since December 2014.

Documentation during seclusion was held in paper format and these were reviewed during both visits. The detail contained in these documents indicated that staff had not followed the Mental Health Act (MHA) code of practice or the trust policies on seclusion or segregation during the most recent episodes of seclusion. Of particular note, there was a lack of clinical detail indicating that continued seclusion was required for a total of eight days before the episode of seclusion/segregation was concluded. During the second visit, this detail was confirmed and a request made for a full investigation into the facts. This issue was also raised with the trust, who stated an external review would be undertaken into the practice of seclusion.

Patients were subject to routine pat-down searches after being on leave and there were handheld body scanners on both units if required. Staff told us random room searches were undertaken, usually at weekends. This was in line with the trust policy, which identified the authorisation of searches and the governance around undertaking these.

Requires improvement

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Staff were able to give a good and comprehensive account of things that would constitute a safeguarding concern and knew how to escalate these. Safeguarding concerns were followed up by the senior social worker based on site. Staff spoke positively of the support they received to do this.

Track record on safety

Saddlebridge Recovery Centre had a major serious and untoward incident in July 2014. This had been investigated by the trust and a comprehensive report and set of recommendations had been presented to the board in December 2014. Managers confirmed that changes to operational practice and procedure were being addressed in relation to the recommendations.

Reporting incidents and learning from when things go wrong

There had been no further serious and untoward incidents on either unit since July 2014 up to the date of the inspection. There was evidence that incidents were being reported via the electronic risk reporting system demonstrated by the number of low or no harm incidents on the system. There was a process in place for reporting, managing and investigating serious and untoward incidents within the trust. Staff could describe the types of incidents and events that should be recorded on the electronic risk reporting system.

Staff informed us that that feedback following incidents was in the form of email, a service newsletter, team meetings and line management supervision. The staff said there were arrangements in place to be debriefed by someone external to the unit team in the event it is required.

The staff were able to describe the type of incidents that would require recording on the electronic risk reporting system. However, we noted that not all incidents of seclusion were being recorded as an event on the electronic risk reporting system. In order to extract an accurate account of the number of specific incidents, such as seclusion, restraint or rapid tranquilisation, these details needed to be added to the system as an incident event. We noted that these incidents were being added as a narrative rather than an event meaning reports about incidents would not always be accurate. This issue was raised during the inspection.

Are services effective?

Good

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

Summary of findings

Our findings

Assessment of needs and planning of care

The Care Programme Approach (CPA) was the underpinning model ensuring that mental health needs were assessed, treatments planned, implemented and their effectiveness reviewed. CPA care coordinator responsibility remained with the locality mental health team where the patient was from. The wards operated a named nurse system and there was evidence in the clinical records that patients were receiving weekly one to one sessions with a named nurse or nominated other.

In line with the National Secure Services Quality Improvement Productivity and Prevention Programme (QIPP), each patient had a My Shared Pathway. This focuses on patients and staff working together to support recovery and aiming for their appropriate discharge from forensic inpatient care at the earliest opportunity. Each patient had an overarching care plan called the Multi-Disciplinary Treatment and Care pathway (MDTTCP) Five of these were reviewed. They were up to date and comprehensive. Needs identified were personalised and written in the first person. There were clear links between the risks identified in the CARSO and HCR-20, and the MDTTCP.

Patients we asked confirmed that they had been involved in drawing up their care plans and had a paper copy of it.

Intervention Plans were completed for specific activities. These identified the aims of the activities and any hazards including risks. Strategies for reducing risks were documented and six of the eight reviewed had been signed by the patient.

Patients had access to an independent mental health advocate (IMHA). There was information about this displayed on the notice boards along with a photograph of the worker and a contact telephone number. During the Mental Health Act (MHA) review in early June 2015, patients confirmed that they understood what advocacy was and that they had met the advocate. Staff reported that the advocate attended multidisciplinary (MDT) meetings if requested to do so by the patient.

We were shown a range of information such as medication and detailed care plans in different formats including pictorial representation and larger print. Patients told us they had access to these and had used them. Two patients on Alderley Unit said they would like to have their section 17 leave forms in an easier to read format. The ward staff told us that the trust is working on providing these at some future point.

Best practice in treatment and care

Detailed assessments were undertaken by the outreach team prior to admission to ensure clinical information was available and this had been shared from the team who best know the patient to the new team on Alderley Unit or Saddlebridge. This was to facilitate a smoother admission to the new unit and to ensure all admissions to the unit were appropriate to meet the needs of the patients:

Patients had access to a range of evidence-based interventions. These included:

Psychological interventions for anger management, substance misuse issues, psychotic experiences and engagement in sexual offenders programmes where applicable.

The psychology staff led with the detailed assessment for the HCR-20 and subsequent formulations. Fortnightly peer supervision meetings were also available for members of the MDT.

Occupational therapists to undertake group and individual work with the patients to regain or develop independence and life skills.

Practical support to undertake activities such as shopping, going to social activities and developing skills to address anxiety and poor motivation.

Dedicated consultant psychiatrist had commenced within the low-secure forensic servicein April 2015. Prior to this, a consultant from the Cheshire and Wirral Partnership NHS Foundation Trust rehabilitation services had provided cover. Patients had access to specialist medication advice and easier access to completion of section 17 leave arrangements.

Occupational therapy staff were able to demonstrate programmes were in place to support people to develop more independent skills such as shopping, budgeting and meal planning which were reflected in the care plans that were in place.

Are services effective?

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There was a range of external activities available to the patients which took place on the units. These included attendance by a fitness instructor to provide one to one sessions, regular visits by an art therapist and a DJ providing a social group and individual tuition

Staff informed us it was difficult to engage some patients in structured activities due to poor levels of motivation and the side effects of medications. There was evidence in the notes that attempts to encourage individuals in activities were attempted on a regular basis.

Each patient had a completed activity plan and these outlined a range of activities. The plans also outlined section 17 leave arrangements. Personal activities such as laundry and attendance at clinical reviews were also detailed on the plans. Plans were available in a range of formats dependent upon the preference of the patient.

There were group attendance sheets in the computer room, the unit based gym and the rehab kitchen. Staff told us these should be completed each time the activity was undertaken in the room. It would appear that the staff were not routinely completing activity attendance sheets. This made it difficult to determine how often groups were occurring or if they were being cancelled.

None of the patients on the units were self-medicating and, when seen by the Mental Health Act reviewer at the beginning of June 2015, some had informed them they had been self-medicating prior to admission.

The senior social worker, as member of the outreach team, worked closely with family members, carers and the home teams where CPA responsibility was held. The outreach team led with identifying appropriate provider organisations to enable step down and discharge from secure services.

The Saddlebridge Recovery Centre and Alderley Unit were part of the Quality Network for Forensic Mental Health having joined in Jan 2014. Members of the network undertook self and peer reviews looking to benchmark service delivery against national standards. The April 2015 peer review noted significant improvements in a number of domains and rated the units as meeting 95% of low-secure standards.

Skilled staff to deliver care

Staff on Alderley Unit confirmed they had regular supervision and this was in line with policy. Supervision arrangements were less established on Saddlebridge Recovery Centre; however, there had been a significant increase in staff receiving supervision since the new manager had come in to post six months earlier with 18 of Saddlebridge staff receiving supervision since April 2015.

The majority of staff had received recent line management supervision within the month prior to the inspection.

Allied health professionals informed us that they have regular supervision with more senior occupational therapy staff who provided line management supervision to staff of a lower band.

There was leadership training for all grades of staff in the trust and a number of the senior staff on the units had undertaken these.

The majority of staff on both Saddlebridge Recovery Centre and Alderley Unit either had an appraisal completed or had one planned.

Multi-disciplinary and inter-agency team work

The multidisciplinary team dedicated to each unit consisted of registered mental health and learning disability nurses, clinical support workers and a consultant psychiatrist. There were dedicated housekeepers for each of the units.

A consultant psychologist, a range of occupational therapy staff and a senior social worker worked across both units. Pharmacy staff attended the units on a minimum weekly basis and available to provide one to one discussion to patients who wished to discuss their medication options in greater detail.

Additional services provided in-reach support dependent up on patient needs including speech and language team, dieticians and physiotherapists.

Patients had named nurse sessions every week and there was a MDT review held every three weeks for each patient. Individual intervention plans were developed following these MDT meetings in response to individual issues and changes in needs and risk. There was evidence of this in the clinical records.

CPA review meetings routinely took place every three to six months. At these reviews all involved in care pathways were invited, subject to agreement by the patient. These included CPA care coordinators, family members and or carers and any other appropriate person such as staff from

Are services effective?

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the step down placement. The My Shared Pathway would be reviewed during these reviews and care plans and risk management plans would be updated as required. There was evidence of this in the clinical records.

During observation of an MDT meeting, the care plan and risk assessment for a patient were discussed and updated and the patient was involved in this discussion.

Handover meetings were held twice daily between the nursing staff as the new shifts commenced. Other members of the multidisciplinary team were given a handover by the nurse in charge prior to undertaking any activities with the patients from the wards. Although these handovers were not recorded the staff said they were comprehensive and ensured they were informed of any clinical changes or issues relating to risks.

The consultant psychologist provided opportunity for reflective practice and peer support via a fortnightly meeting held on the unit.

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

A MHA review was undertaken by the CQC at the beginning of June 2015 on Saddlebridge Recovery Centre. This review highlighted a number of concerns which included:

- difficulties locating some documents including risk assessments relating to section 17 leave;
- inconsistent evidence that section 132 rights were being adequately explained;
- Certificate of consent forms were not up to date and there were inaccuracies in some of these.

There was a requirement to provide an action plan to identify how these issues were to be rectified and to include timescales for when these actions would aim to be achieved. This was submitted on 17 July 2015 shortly after the return visit.

A sample of required documentation was reviewed during the inspection and a number of remedial actions had been taken by the unit. Consent to treatment forms were up to date and located alongside individual medication charts. Risk assessments were located within a clearly marked file alongside the section 17 leave and all staff knew where to access these.

Staff described that section 132 rights were reviewed with patients on a regular basis and this was recorded within the electronic clinical record. There was evidence in one randomly selected record that section 132 rights had been reviewed and the patient had signed to confirm this on four occasions in the eight months prior to the inspection.

During the inspection, the records relating to the two most recent incidents of seclusion were requested. Staff were unable to locate the contemporaneous notes relating to one of the periods of seclusion. This was because these clinical records had not been stored with the clinical records for the patient and were later located in the wrong file.

Good practice in applying the Mental Capacity Act

Nursing staff, that were asked, had received e-learning Mental Capacity Act training but did not appear confident or to have a full and comprehensive understanding of the detail of the Mental Capacity Act.

A patient informed the MHA reviewer during the inspection on 5 June 2015 that they were unhappy that they were no longer self-medicating. They stated they, and a number of other patients had been self-medicating prior to their admission to Saddlebridge Recovery Centre but they had been stopped from doing this when they were admitted. At the time of the inspection, no patients were self-medicating.

An assessment of a patient's capacity to consent was routinely carried out by medical staff on admission and as part of the multidisciplinary meetings. Although this did not happen at the MDT meeting attended during the inspection, there were notes of this occurring within the electronic clinical records.

Where required the psychologist and social worker assisted in best interest decision making and best interest meetings were held where required although we did not seek any examples of this.

Requires improvement

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

A patient stated he found the same staff nice and friendly and another patient that he felt able to raise complaints to staff and that he found them approachable. The majority of patients on Alderley Unit spoke positively of their interactions with staff.

Two patients told us they had heard staff talking in a derogatory manner about fellow staff. A patient stated that patients on Saddlebridge Recovery Centre had been reluctant to complete comment cards and place these in the box left on the unit. This was because they were worried that staff may access the cards and read the confidential details. This was confirmed when the trust reviewed CCTV footage. The trust acted immediately to investigate the incident and take appropriate action.

During the inspection, all observed interactions were appropriate, polite and professional. These included one to one exchanges and behaviours observed in the multidisciplinary team meeting

The involvement of people in the care that they receive

There was evidence that patients were involved in their assessments, care planning and evaluation of progress. My shared pathway and care plans were written in the first person, the majority of the individual intervention plans that were reviewed were signed by the patient concerned and patients were observed to appear comfortable to discuss progress in the MDT meeting.

The wording used within a care plan that had been implemented during a recent episode of seclusion did not reflect that it had been agreed with the patient and did not appear to identify the patient's preferences and wishes. The plan did not record strategies that the staff could use in order to reduce the need for seclusion.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

Admissions and discharges were overseen by the North West specialist commissioning team. The majority of patients were admitted directly from court, prison or stepped down from more secure services. The average length of stay was around two years.

The outreach team undertake assessments contacts and visits prior to admission and maintained this contact after discharge from the units for a number of weeks.

The units had a good record of successful discharges and worked closely with other units within Cheshire and Wirral Partnership NHS Foundation Trust such as Lime Walk rehabilitation ward to facilitate transfers where appropriate. Where patients were being discharged to a community placement there was joint working with the local community mental health services within that area.

Both units were relatively newly opened at the time of the inspection. Saddlebridge Recovery Centre reopened to admissions in December 2014. There has been a phased programme of admission working with secure commissioning services and at the time of inspection the 15 bedded unit had 11 patients.

Alderley Unit had relocated to a purpose built unit on the same site and had been open since March 2015.There were seven patients on the 15 bedded unit and there were future plans in place for a further four admissions over a graded period of time.

Three patients were involved in the running of the Sunny Café based on the Soss Moss site. This new service had opened on site in April 2015 and those working had received additional food and hygiene level 1 training. Patients confirmed they were developing additional skills in food preparation, budgeting and handling money through this work.

CPA responsibility remained with the community team that the patient had been admitted from and contact was maintained throughout the admission to the units via the three to six monthly CPA reviews. There was evidence of this within the clinical records.

The facilities promote recovery, comfort, dignity and confidentiality

The environmental facilities provided at both units were well equipped to meet the needs of patients to spend time in their rooms, socialise within the main lounge areas and gardens or to spend time in smaller quiet areas available throughout both units.

Meeting the needs of all people who use the service

Patients on Saddlebridge Recovery Centre told us they attend and contribute to daily community meetings and they often raised concerns about the size of the meal portions. There were no minutes taken in these meetings.

Concern with the size of portions were raised in the "My service My say" minutes but there are no actions recorded about what the staff were doing regarding this. The ward manager described that a dietician had recently attended the Saddlebridge Recovery Centre but had not committed to provide ongoing interventions.

Issues re portion size and concerns with the standards and quality of food was also raised during the Mental health Act review visit on 5 June 2015 and also highlighted in the Quality Network for Forensic Mental Health peer review report in April 2015.

There were a range of activities available on a daily basis either on the unit, on the Soss Moss site at York House or within the local community. Many of these activities were based around individual patient's likes and interests. There were comprehensive weekly activity sheets recorded within the electronic clinical records and there were corresponding section 17 leave forms and individual intervention plans to support these activities.

Ward staff had access to two trust vehicles to support undertaking community based activities. This was needed as the units are located approximately three miles from the nearest village or town and there was limited access to public transport in the locality.

Are services responsive to people's needs?

Good

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

Two patients worked at a large local charity and three worked in the café based on site. There were a significant number of activities located within the community at local leisure centres or towns.

During this inspection and during the MHA review on 5 June 2015 patients stated that on occasions planned activities were cancelled due to staff shortages. It was difficult to identify which activities and on which dates these had been cancelled due to staffing shortages as the activity note held within the clinical record was not routinely completed and so detail could not be extracted.

Patients on Alderley Unit confirmed they had been involved in choosing the colour and choice of design for walls and flooring when the new Alderley Unit was being built.

Patients stated they regularly attend the "My Service My say" meetings held fortnightly within the units and their involvement was noted in the minutes of those meetings.

There were large pleasantly furnished family rooms located away from the ward to facilitate children visiting. These rooms had notice boards and posters detailing information about carer assessments and carer support groups and organisations.

Listening to and learning from concerns and complaints

A patient stated he had made two complaints and that he had not received a response to either. In one instance he stated the staff he complained about had returned to work the following day and no one told him what actions had been taken to look into his complaints. This was escalated during the inspection and the trust provided feedback that the complaints had been followed up and in one instance the patient had been told directly the outcome of the process followed. Feedback provided to the patient following the second complaint was less clear.

The unit regularly holds a "my Service my say" meeting. We were informed that this meeting was used to communicate compromises and agreements about take away meals being brought to the unit and other issues of importance to the unit at the time. There was evidence of these discussions in the minutes from those meetings.

The trust were asked to confirm he number of complaints that have been received since the unit reopened in December 2014 and the two listed above were the only ones confirmed.

Are services well-led?

Requires improvement

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

Summary of findings

Our findings

Vision and values

Line management documentation incorporated the 6Cs. These have been identified by NHS England as care, compassion, commitment, competence, communication, and courage. This reflected the trust commitment to embed the values of compassion in to the behaviours and the attitudes of their staff. The majority of staff confirmed they were in receipt of regular line management supervision and we were shown examples of the completed documents.

Staff confirmed they had regular contact with the senior management team and that the modern matron and other senior managers attended both units regularly. There had been recent visits from members of the executive team.

Staff described different cultures within the ward team on Saddlebridge Recovery Centre. These included variation in imposing restrictions and enforcement of rules dependent upon which staff were on duty. Staff description of this indicated a tension with the team and division between the newer staff and those who had worked on the ward for some considerable time. Some staff referred to these behaviours as bullying within the staff team.

Good governance

Team members were able to describe systems and processes that were in place for both the patients and the staff team to raise concerns. There were a number of incidents that had been escalated and there was evidence that action had been taken in response to these concerns.

The staff were able to describe the type of incidents that would require recording on the electronic risk system. However, it was evident that not all required incidents were being recorded. A request for additional information demonstrated there had been three episodes of seclusion that had not been initially reported. This issue was escalated during the inspection.

In addition to the non-recording on the electronic risk system, there were episodes of seclusion and segregation that had not been appropriately recorded and in one case the notes were not located within the correct clinical record.

On reviewing the seclusion documentation made available during the visit the wording used to describe the patients' presentation did not indicate that continued seclusion had been warranted. Multiple MDT members were involved in the process of reviewing that specific episode of seclusion and all failed to effectively raise safeguarding concerns. Concerns relating to this were escalated to managers at the time of the inspection.

A "safety metric audit" was undertaken monthly by the modern matron and an action plan generated to address any shortfalls that were indicated in the audits carried out that month. The outcomes from these were displayed in the reception area of the units. Those audits had not identified issues relating to care planning documents or the use of non-person-centred terminology within those documents. This would indicate this is not a significant issue within the service but this concern was raised with the trust in order to seek further assurance.

Patient-led assessments of the care environment inspections were regularly undertaken and the most recent report had been rated as outstanding.

Leadership, morale and staff engagement

The staff teams on the two units reported different levels of satisfaction with their roles, feeling of job satisfactions and relationships with peers.

The trust informed us that the sickness rates for Saddlebridge Recovery Centre varied between 9 and 23% in the six months since the unit had opened. In the month prior to the inspection, the staff sickness level was 18%. The majority of this sickness was long term.

Staff described tensions within the team regarding the consistent application of new operational rules and reduced restrictions. We were informed that some staff had found it difficult to cope with conflicts between colleagues and that this had been raised in line management supervision. We were told these had been discussed within supervision and escalated to the senior management team.

Are services well-led?

Requires improvement

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

Commitment to quality improvement and innovation

The facilities and the environments on both sites were of a good standard and there had been clear investment in the quality of the long stay units.

Saddlebridge Recovery Centre and Alderley Unit engaged in the Quality Network for Forensic Mental Health and had improved peer rating reports across the quality domains in the most recent peer review audit dated April 2015.This demonstrated that there had been some significant improvements since first peer review and it scored 95% compliance across the standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated activities) Regulations 2014 Person - centred care On Saddlebridge Recovery Centre, care plans did not always show that the patient had been involved in their development. Patients were not always asked about their preferences about how care was provided. Blanket restrictions were in place which were not based on individual risk. This was a breach of Regulation 9(1)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated activities) Regulations 2014 Safeguarding service users from abuse and improper treatment On Saddlebridge Recovery Centre, a patient had been kept on seclusion for a prolonged period when records showed the patient was settled. On Saddlebridge Recovery Centre, Patients told us that some staff did not treat them with dignity and respect. Patient comments boxes, provided by CQC for patients to provide feedback in confidence, had been opened by a member of staff and read in front of a patient. This was a breach of Regulation 13(1)(2)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014 Good governance On Saddlebridge Recovery Centre, there were a number of environmental risks that had not been identified and mitigated against. On Saddlebridge Recovery Centre, actions identified in plans had not been completed in a timely manner. Some issues had recurred such as low staffing and blanket restrictions which had not been addressed effectively. On Saddlebridge Recovery Centre, monitoring systems had failed to identify when quality of records or care was not at the required standard. This was a breach of Regulation 17(1)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated activities) Regulations 2014 Staffing On Saddlebridge Recovery Centre, there were not always sufficient numbers of staff on duty to provide care and meet the needs of the patients. This was a breach of Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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