

Good 

Mersey Care NHS Foundation Trust

High Secure Services: Ashworth Hospital

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) |
|-------------|---------------------------------|---|--------------------------------------|
| RW404 | Ashworth Hospital | Arnold Ward Blake Ward Carlyle Ward Dickens Ward Forster (Newman) Ward Gibbon Ward Johnson Ward Keats Ward Lawrence Ward Macaulay Ward Ruskin Ward Shelley Ward Tennyson Ward | L31 1HW |

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / 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 high secure services at Ashworth Hospital as good because:

- Wards were clean and well furnished. Mirrors and closed circuit television cameras were used to ensure that patients and staff were safe and monitored on every ward. Staffing was being managed by ward managers and matrons, using a safe staffing system, and we were informed that 53 new staff had been recruited to the trust and would soon be ready to join the teams. National policies relating to night time confinement and long term segregation were being followed. Medication management followed guidance, and the introduction of an electronic prescription system had improved monitoring. Incidents were reported and appropriate actions were taken to deal with these incidents.
- Care plans were comprehensive and holistic across the service. Staff involved patients in the development of their care plans and gave copies of care plans to patients when the patient agreed to accept them. Staff were able to access further specialist training from external bodies, up to and including masters level qualifications. The care records indicated that staff paid as much attention to patients' physical healthcare as they did to patients' mental health. The provider had recruited psychologists to the service. This improved the patients' access to effective psychological therapies. All patients were detained under the Mental Health Act. Staff across the service adhered to the guidance in the Mental Health Act Code of Practice. However, the trust Mental Health Act policy referred to an out of date Code of Practice; the trust was using the current Code of Practice. The Mental Capacity Act was applied across the service, and we saw evidence of capacity assessments in care records.
- Interaction between patients and staff was seen to be of a high standard, empathic and professional. Patients told us that staff treated them with kindness and respect. We observed a patient forum and saw excellent interaction between staff and patient representatives, with matters discussed openly and with due consideration for all. We spoke with carers of patients and were told that, generally, they were positive about the service. Some carers raised points that we looked further into, and were assured that the service was acting in the best interest of patients. Patient viewpoints were listened to and helped to define the service.
- The service was adhering to national recommendations regarding times for referral and assessment of patients. Wards were updated and refurbished on a rolling basis, as older wards were redecorated and improved. Forster ward had recently closed and re-opened as Newman ward, the new ward being appreciatively more modern than the old ward. The service had plans in place for patients from different cultures and countries, considering food, treatment and religious aspects.
- The trust visions and values were embedded in the service. All staff knew of the values of the trust, and the direction the trust wanted to move. We saw evidence of senior staff involvement in the service, including at chief executive level. Staff were involved in clinical audit; the service itself had been involved in a number of audits in the 12 months prior to the inspection. Ward managers felt they had the authority to do their job. Staff told us that morale on the ward was quite high, but it would improve more when new staff joined the teams.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Wards were clean, and the environment in and around the wards were risk assessed on a regular basis. Convex mirrors mitigated any blind spots on the ward, and closed circuit television cameras were in use 24 hours a day, the system closely monitored and controlled regarding access to footage and maintenance.
- Staffing levels were monitored and adjusted by a safe staffing system, and recent recruitment had been successful. Risk assessments for patients were comprehensive and up to date, and staff had a good knowledge of risks and signs of behavioural and mental deterioration in patients.
- There was a robust medicines management system in place, and there was good practice ongoing across the service.
- Safeguarding procedures were in place and followed by staff, and relationships with other agencies were robust. Seclusion and long term segregation were monitored and used according to policy. Voluntary confinement was used in order for patients to be in control of their environment should they feel the onset of a problem, with the patient being able to request release from their room when they felt safe. A reducing restrictive practice group had made significant improvements in patient welfare and treatment.
- We saw that night time confinement was used across the service. Consistent with Directions from the Department of Health relating to night time confinement, staff offered all patients a minimum of 25 hours of meaningful activity during the working week.
- Staff reported incidents as and when they occurred, with learning from such incidents shared.

Good



Are services effective?

We rated effective as good because:

- Patients had comprehensive and holistic care plans that indicated patient involvement, and were regularly updated. The recent increase in psychology recruitment showed that a range of support therapies were in place, and the multidisciplinary team meetings in the service helped to identify therapies specific to patient needs.

Good



Summary of findings

- There was evidence of ongoing staff training, with some staff involved in specialist master's degree training.
- Staff showed a good knowledge and understanding of the Mental Capacity Act, and how to apply the five principles of capacity assessment. We saw evidence in care records of capacity being considered and witnessed discussions regarding capacity in multidisciplinary team meetings and handover meetings.
- We saw that the Mental Health Act was followed, and paperwork regarding detention and patient rights were maintained. Poor training data provided by the trust proved inaccurate regarding training in the Mental Health Act; ward based figures showed the training was much higher than suggested.

However:

- The Mental Health Act policy for the trust referred to in October 2017. We saw no evidence that this had a detrimental effect on practice.

Are services caring?

We rated caring as good because:

- We were told by patients that staff treated them with respect and kindness. This was observed during the inspection, with instances of rapport and good interaction noted. There was evidence of understanding of individual patient needs.
- We observed a patient forum in which patient representatives from each ward took part, raising issues and suggestions as a means to improve patient life on the wards. We saw evidence of careful consideration for a number of topics raised by patient representatives, with standing items such as night time confinement and patient experience questionnaires in the minutes of the meetings. The minutes were displayed in each ward on a noticeboard.
- Carers were generally positive in their comments about the service. We looked into some carer concerns and were assured that the trust was acting in the best interests of the patients.
- Patient involvement in the service was apparent; the trust's 'no force first' policy had been designed and delivered with patient input. The patient's viewpoint was strongly considered by the reducing restrictive practice group.

Good



Summary of findings

Are services responsive to people's needs?

We rated responsive as good because:

- Access and discharge to and from wards was well managed, with assessment and referral times within national guidelines.
- Ward environments were updated on a rolling basis, with older wards being decorated and improvements added as required. There were rooms for a number of activities, with each ward able to offer a variety of activities to patients.
- We saw that physical healthcare needs were being met. We observed discussion between staff and patients regarding aspects of their physical health, education about good diet, and how to manage existing physical health problems.
- Staff ensured that patients who did not speak English as a first language had access to interpreters. Patients told us that the service provided them with reading materials in their own language.
- Religious consideration was given importance, with a chapel built in the secure perimeter of the hospital, and access to a selection of religious clergy.

Good



Are services well-led?

We rated well led as good because:

- Staff were aware of the vision and values of the trust, and these had been successfully integrated into the day-to-day operation of the service. There was involvement from senior staff, and the chief executive was involved in a number of programmes designed to improve staff interaction and access to the chief executive.
- Mandatory training was monitored by ward managers. Supervision and appraisals took place, and staff told us they always had time for supervision.
- Staff were involved in clinical audit and the results were used to improve the service. Key performance indicators were used to drive improvement.
- Ward managers told us that they felt they had the authority to do their role, and that working closely with modern matrons had allowed the service to benefit from the working relationship, as empowerment allowed related decision making within the service for the service.

Good



Summary of findings

- Staff felt that morale on the wards was quite high, but would be better when newly recruited staff were introduced to the wards. Staff were happy with the recent addition of extra psychological input on the wards, and felt this was better for the patients.

Summary of findings

Information about the service

Ashworth Hospital is one of only three hospitals in the country providing services for patients who require treatment and care in conditions of high security. The service is divided into two main care pathways: one for men with a mental illness, and one for men with a personality disorder with or without a mental illness.

The majority of patients come from the North West, West Midlands or Wales, and most are admitted from prison, through the court system or from a secure unit. Patients are admitted because they present a significant danger to themselves and/or other people. Patients remain in the high secure service until they are safe and well enough to move to a medium secure or other unit.

Up to 210 patients can be admitted in 13 single storey semi-detached wards. The wards are arranged in clusters around wide-open areas and each ward has its own garden.

The wards were:

For patients with a personality disorder or a personality disorder and a mental illness:

Arnold ward – 12 beds – high dependency ward

Forster (Newman) ward – 20 beds – low/medium dependency unit

Keats ward – 12 beds – high dependency ward

Ruskin ward – 20 beds – medium dependency ward

Owen ward – 12 beds – medium dependency ward

Shelley ward – 20 beds – medium dependency ward

For patients with a mental illness:

Tennyson ward – 12 beds – high dependency ward

Carlyle ward – 20 beds – medium dependency ward

Johnson ward – 12 beds – high dependency ward

Dickens ward – 20 beds – medium dependency ward

Lawrence ward – 12 beds – high dependency ward

Gibbon ward – 20 beds – medium dependency ward

Blake ward – 12 beds – high dependency ward

We last inspected Ashworth Hospital in June 2015. This was part of an inspection of all forensic services, which included low, medium and high security. We rated forensic services as good, and there were no breaches of regulation.

Our inspection team

The team was led by:

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

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

The inspection team that visited Ashworth Hospital comprised five CQC inspectors, a CQC assistant inspector,

a CQC pharmacist inspector, a CQC head of hospitals inspection, a Mental Health Act reviewer, two consultant forensic psychiatrist specialist advisors, a speech and language therapist with management experience in high secure services and an expert by experience. An expert by experience is someone who has used or is using mental health services.

Summary of findings

Why we carried out this inspection

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

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

We last inspected Ashworth hospital as part of a comprehensive inspection of Mersey Care NHS Foundation Trust. At that time, we rated the forensic inpatient services, of which Ashworth Hospital was a part, as good overall; with a rating of good for each of the five key questions: safe, effective, caring, responsive and well led.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all 13 of the wards at Ashworth Hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 62 patients who were using the service
- spoke with three carers of patients at the service
- spoke with the managers or acting managers for each of the wards
- spoke with 69 other staff members including consultant psychiatrists, junior doctors, nurses, an activity coordinator, psychologists and social workers

- interviewed senior staff members which included the director of security, the trust lead for the reducing restrictive practice group, the trust lead for personal safety training and the positive intervention programme service (PIPS) team
- held one focus group specifically for ward managers, one focus group for matrons of the service, and focus groups for staff and carers
- attended and observed four handover meetings and three multi-disciplinary meetings
- visited and reviewed the patient education centre and the welcome centre for Ashworth Hospital.
- collected feedback from eight patients using comment cards
- looked at 87 treatment records of patients
- carried out a specific check of the medication management on four wards, and reviewed 101 medication charts
- looked in detail at a sample of specific seclusion reports, restraint records, long term segregation and night time confinement, and Mental Health Act paperwork across the service
- looked at policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke with 62 patients in the service. Most patients we spoke with were positive about their care. There were good comments relating to food standards, the skill and empathy of the staff in the service, and the variety of courses available to patients.

One patient told us that he had an ongoing health problem, but that he had access to pain relief when needed and regularly saw a doctor. We spoke with a patient using an interpreter in his own language. He stated that the trust had provided him with books in his own language, but he was not particularly happy with the food being served: he had no special dietary requirements for health or religious reasons.

We received eight comment cards in total regarding high secure services. Two were positive in nature, three were negative, two cards were mixed and one card was unclear. Staffing levels were mentioned in one card, suggesting more staff were needed on the wards. There was mention of problems with medication management on a ward. We included a review of medication management practice in the inspection and found nothing untoward occurring on the ward.

Good practice

The positive intervention programme service team was a proactive service that worked with the most challenging patients, as well as advising and monitoring ward staff during interactions with challenging patients. The team recognised the natural fear of both staff and patients of possible injuries during certain situations, and the team manager and personnel had worked hard to limit such injuries by adapting the “no force first” policy into their culture. Training had been adapted to move from physical techniques to less restrictive ways of dealing with a situation.

The reducing restrictive practice group had been instrumental in the introduction of least restrictive practices within the service. It had widened access to these practices by developing them with a view to being used in other services, including high secure prisons.

Ashworth Hospital has the only dedicated research centre in the United Kingdom based within a high secure psychiatric facility. The centre is partnered with a local university, and research was steered by a multidisciplinary committee from different fields at Ashworth. Work relating to the introduction of the no force first initiative at three high secure prisons has been

undertaken, with a view to five other high secure prisons accepting the programme on completion of a successful pilot. Research with other universities has taken place in conjunction with the research centre to evaluate practice and outcomes.

Staff at Ashworth have provided training and consultancy to divisions within the trust, other NHS mental health and private sector providers, as well as Her Majesty's Prisons high secure estate, and have shared these innovations at national and international conferences.

The trust used a health promotion programme called Dr Feelwell designed to improve physical health and wellbeing in both staff and patients. The programme was recognised in the National Service User Awards 2016 as winner in the health and wellbeing category. The programme had been rolled out to other divisions in the trust and had been taken up by an external school sport partnership.

The trust, in partner with a consulting group, was involved in the development of the Secure Recovery Star, this tool having been embedded in high secure services for three years.

Summary of findings

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that the Mental Health Act policy is updated, and remove references to the out of date Code of Practice.
- The provider should ensure that the central records of how many staff have undertaken mandatory training accurately reflects the true figures.

Mersey Care NHS Foundation Trust

High Secure Services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Arnold Ward
 Blake Ward
 Carlyle Ward
 Dickens Ward
 Forster (Newman) Ward
 Gibbon Ward
 Johnson Ward
 Keats Ward
 Lawrence Ward
 Macaulay Ward
 Ruskin Ward
 Shelley Ward
 Tennyson Ward

Ashworth Hospital

Mental Health Act responsibilities

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

We found that staff understood the Mental Health Act and its application across the service. We saw evidence that the current Mental Health Act Code of Practice was being used in relation to detained patients.

Consent to treatment documentation was well maintained and accurate. With regard to medication management, we found that the electronic system in use by the service reflected the need for relevant Mental Health Act

documentation, and this was recorded. Staff informed patients of their rights under the Mental Health Act. This was recorded, and there was a robust mechanism to check that this was repeated when necessary.

There was a dedicated Mental Health Act administration team that ensured advice and support was available to staff when required.

Detailed findings

However, the trust's Mental Health Act policy referred to an out of date Mental Health Act Code of Practice. We could find no evidence that this had had a detrimental effect on practice. The policy was due to be reviewed by the trust in October 2017.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff throughout the service had a good knowledge of the Mental Capacity Act, and some carried small reminder booklets that gave advice on the principles of the Act and how to apply them. A staff knowledge audit suggested that further training in the Mental Capacity Act should be considered in the future.

Mental Capacity Act training was mandatory across the service. There was some discrepancy between the training

data supplied by the trust and findings on the wards. The trust-wide data suggested that training in the service stood at 30.7%. However, records on the wards showed much higher figures, and an internal audit in January 2017 showed that the trust Mental Capacity Act training figure stood at 88%.

Are services safe?

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

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

Our findings

Safe and clean environment

The wards at Ashworth Hospital were spread over a wide area of space that included a chapel, a large gymnasium building, administrative centres and other buildings that allowed patients to take part in various meaningful activities. The wards were semi-detached, in that each ward had gated access to one other ward, allowing support and movement should this be required. Each ward had access to outdoor space. Patients were risk assessed before being allowed either free or accompanied access to the garden. A programme of refurbishment was ongoing, with wards being updated one at a time. Patients and staff moved to a different ward whilst their ward was upgraded. For example, Newman ward had been refurbished and reopened the week before inspection. Patients moved into Newman ward from Forster ward. Improvements included more natural light in communal areas, upgraded facilities for serving of drinks, and pill slots in bedrooms for night time medication. The windows in the slots had been boxed in and secured with locks, so privacy was assured and the woodwork was in keeping with ward décor. Ward flooring was designed to limit noise carrying into the sleeping area.

There was a well-established system in place for the management staff's access to keys. Each staff member who had access to keys for the secure services was issued with a belt, a pouch and a strap. These were made of a sturdy material to prevent tampering. During the inspection, we saw that staff used the pouch, belt and strap to secure their keys. All staff completed mandatory security training each year. Staff understood the meaning of relational security and how it applied to their role, and what was expected of them.

All 13 wards in the high secure service had a ligature risk assessment completed in the 12 months prior to inspection. Environmental suicide risk assessments were held on each ward, and these were inspected and found to be up to date and comprehensive. Staff we spoke with knew the ligature risks on the wards, and were aware of the risk management policy. Physical healthcare was a consideration throughout the service, in line with the 'No Force First' policy of the trust.

The wards were clean and tidy. This reflected the 2016 patient led assessments of the care environment (PLACE) findings that showed Ashworth Hospital scored the same as the national average for cleanliness (98%).

Blind spots were mitigated by the use of mirrors, including in bathrooms, and ward design. For example, the night station allowed for constant observation of the sleeping areas of the wards. Staff were constantly moving around the ward area, interacting with patients and clearly observing moods and attitudes of patients. There was no unsupervised access to rooms with ligature points. All staff wore personal alarms and each room had call buttons to alert nursing staff. We observed that staff on Blake ward responded quickly and calmly when an alarm on Arnold ward was activated. Closed circuit television systems were evident on all wards, with checks in place to ensure that the system was active and recording at all times.

Each ward had a small clinic room that contained an examination couch, blood pressure monitoring equipment and weighing scales. Blood pressure monitoring machines were in use across the service, we noted different types of manual and electronic machines. Those machines that required annual calibration were in date. Oxygen bottles were checked and found to be in date, as were the masks attached to the cylinders. An oxygen cylinder on Blake ward was out of date, but was immediately replaced when noted by the inspection team. Sharps containers were checked and labelled correctly. Fridges and room temperatures were monitored and recorded on a daily basis. Ligature cutters were available should they be needed. Wards were allocated as a first responder ward, and as such emergency resuscitation equipment and other emergency equipment was stored in the clinic.

The seclusion rooms in each of the wards met the criteria laid down in the Mental Health Act Code of Practice. The seclusion rooms allowed clear observation, and bedding and mattresses were safe. Communication was two way, with a nurse call button should it be needed. On Owen ward the seclusion room had under floor heating to ensure temperature could be controlled, as well as an air circulation system. Television screens and digital clocks were available in the updated seclusion rooms. Arnold ward had two 'super seclusion' rooms that had showers as

Are services safe?

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well as toilet facilities; the newly refurbished seclusion room had air conditioning and heating. In two of the wards the digital clocks were not working, but this had been accommodated for by the use of wall clocks outside of the rooms, and new clocks had been ordered. All seclusion rooms had a view of a working clock.

In the most recent annual audit by the National Offender Management Service (NOMS), Ashworth Hospital received a rating of 100% for security.

Safe staffing

At the time of the inspection, high secure services had 193 patients detained at Ashworth hospital.

High secure wards had 410 substantive staff at 31 December 2016. Between 1 January 2016 to 31 December 2016, 13% of all staff left the service. Keats and Ruskin ward had staff leaving rates of 19% and 18% respectively during the same period. The sickness rate for the whole service was 11% during this period. The total number of vacancies for the service was running at 5% for the period 1 January 2016 to 31 December 2017. Across all wards, the bank usage to cover sickness, absence or vacancies was 12,592 shifts for the same period. Managers had been unable to fill 7,590 shifts. High secure wards did not use agency staff because of the high level of security training required to work with the patient group. Johnson ward also used the highest number of bank staff with bank staff covering 1,638 shifts, and Arnold ward followed with 1,523 shifts filled.

The trust used a 'safe staffing system', whereby wards had their establishment figures, then set a lower 'safe staffing' level. The latter was the minimum number of staff that allowed the wards to function safely. The trust informed us that they were meeting the requirements for lower safe staffing levels for inpatient services. The guidance for staffing levels had been designed to support decision makers at ward/service level. The guidance supports the professional judgement made by an experienced professional at the front line. The trust used the 'Telford Model of Professional Judgement' to agree the most appropriate size and mix of ward nursing establishment. This approach was both consultative and engaging. It entailed calculating registered and unregistered staffing requirement hour by hour over a 24-hour period and converting the requirement into whole time equivalents. Managers then mapped planned requirements against current budgets to identify any variance. Each morning, ward managers were empowered to review staffing figures.

They would move staff within the service to cover shortfalls in staffing. This often meant that wards would be staffed at the safe staffing level, as opposed to full establishment. Both patients and staff commented that they would prefer more staff on the wards. However, we saw no evidence of obvious impact due to staffing numbers during the inspection. Many staff were aware that new staff had been recruited, and were optimistic about the future staffing on the wards. The trust was involved in a National Programme for Safe Sustainable Staffing, and this involvement helped guide safe staffing in the service.

Mental health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Staff fill rates compare the proportion of planned hours worked by staff (nursing and care staff) to actual hours worked by staff (day and night). We saw the safe staffing report for December 2016. Ten of the thirteen wards had fallen below the 90% threshold establishment figure for registered day nurses or day care nursing assistants in December 2016: it should be emphasised that on no occasion were both registered staff and nursing assistants both below the figure on the same day. It was noted that the report showed that the monthly shortfall in a staff group was compensated by an increase in the other staff group. This meant that a shortfall in trained staff meant an increase in nursing assistants, or possibly a shortfall in nursing assistants covered by trained staff. The months prior to December 2016 all showed established staffing figures. The reason for the shortfall in December 2016 was given as unfilled vacancies.

In December 2016, Arnold ward reported the lowest fill rate for registered nurses at 68% and Forster (now Newman) ward had the lowest fill rate for day support staff at 81%. Tennyson ward had the highest fill rate for day support staff, 13% above the threshold of 125% with 138%. For night staff, seven of the 13 wards fell below the 90% threshold for night nurses and five above 125% for night nursing assistants. Both Carlyle and Ruskin wards reported night fill rates for nurses of 67%, 23% below what was planned, whereas Gibbon ward reported 184% fill rate for night support staff, followed by Blake ward reporting a fill rate for night support staff with 174%. The safe staffing system allowed for shortfalls in staffing to be covered.

Are services safe?

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

During the inspection, senior managers informed us that there were 42 staff vacancies at Ashworth Hospital. They also told us that 53 new staff had been recruited and were in the process of joining the teams. This was confirmed in the minutes of the Patient Forum for 22 March 2017.

Night time confinement was operational practice across high secure services, with patients being locked in their rooms from 9.15pm until 7.15 the following morning. The director of security told us that the practice was initiated in 2011 under the High Security Psychiatric Services (Arrangements for Safety and Security) Directions. The policy was updated for all high secure hospitals by the Department of Health in 2013. Staffing levels at night were, consequently lower than during the day. This cost consideration allowed for more staff during the day, to facilitate meaningful activities for patients. We saw that night time confinement was a standing item agenda on patient forums in high secure services. The Patient Forum minutes for 22 March 2017 showed that patients were happy with support from staff if they had any problems at night. Of the 193 patients detained at Ashworth hospital, only one patient had a care plan that allowed night time confinement to be waived.

On Owen ward, as a means of meeting the 25 hours of meaningful activity required for each patient under Department of Health directions, a chart was kept on a noticeboard that indicated that, if patients met a certain point, the ward would purchase a sound bar system for the television. This was used as a means of incentive for patients to take part in activities. In the months December 2016 to February 2017, the average hours of meaningful activity attended by patients in the service was between 26.5 hours and 28 hours. This contrasted with the average amount of hours of meaningful activity offered in that period which ranged from 33.5 hours to 35.3 hours. The maximum hours attended in the same period ranged from 38.9 hours to 41.7 hours, whilst the minimum hours attended ranged between 16.6 hours and 17.8 hours.

As at 21 January 2017, the mandatory training compliance for high secure services was 83%, against the trust target of 95%.

Assessing and managing risk to patients and staff

Each patient had a risk assessment that was comprehensive and regularly updated. The service used the historical clinical risk (HCR-20) assessment, coupled with the short-term assessment of risk and treatability

(START) assessment, and the Tilt high-risk assessment. We attended four handovers of patient details and noted that risk was discussed in each one. Nursing staff told us that risk was always discussed, in order to keep patients and staff as safe as possible.

High secure wards had reported 214 incidents of restraint in the 12 months between 1 January 2016 and 31 December 2016 that involved 64 different patients. There were 56 incidents of long-term segregation and 184 incidents of seclusion and it was policy not to use mechanical restraint. There were 46 incidents of prone restraint, which accounted for 30% of the restraint incidents. In addition, of the 214 instances of restraint reported, 36 (17%) resulted in rapid tranquilisation. Lawrence ward had the highest numbers for seclusion with 33, and for restraint with 77. On the same ward there were 22 incidents of prone restraint and 23 uses of rapid tranquilisation. Arnold ward had the highest number of incidents of long-term segregation in the 12-month period with 14 incidents. Holistic programmes to reduce long-term segregation were seen as successful, with one patient who had been in long-term segregation for 12 years having his segregation ended.

High secure services used a positive intervention programme service (PIPS) team as an approach to working with difficult to engage patients. We interviewed the trust lead for the team and were told that all patients in long term segregation were supported to leave their rooms on a daily or regular basis. This was called association time, and gave the patient a change of environment, and allowed staff to ensure that rooms were cleaned and maintained. Long term segregation was used when patients were provided with nursing care in isolation for longer periods than they would in seclusion, due to the risk of harm to themselves or others. The PIPS team also assisted staff and provided guidance on safe but less restrictive ways of working with patients.

The trust had a programme they used to reduce the use of restrictive interventions on their wards, called 'no force first', and this was a central priority for the organisation. All wards in secure and local divisions have had engagement sessions by a facilitator and an expert by experience. A pilot of evidence-based tools, care zoning, the DASA (dynamic appraisal of situational aggression) checklist and on-page plan, in addition to the no force first approach, had commenced on six wards in the secure division to evaluate

Are services safe?

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

if these approaches further improved the efficacy of no force first. The dynamic appraisal of situational aggression is a tool developed in 2006 to assess the likelihood that a patient would become aggressive within a psychiatric inpatient environment.

A clinical model, the HOPE(S) and barriers to change checklist had been developed to reduce long-term segregation and had been incorporated into the trust's independent monthly monitoring reviews. HOPE(S) meant, "Harness the system and engage the person, Opportunity for positive structured activity, Preventative and protective factors, and Enhance coping skills". A reducing restrictive practice policy had been approved. The personal safety service training delivered to all clinical staff had been modified to include no force first principles and included a focus on the prevention of conflict and incidents.

Monitoring groups reviewed all restrictive practices in the clinical divisions. We interviewed the trust lead for the reducing restrictive practice group and were told that there had been a 22% reduction in the number of restraints in secure services. The HOPE(s) and barriers to change checklist relates to a high secure prison environment. Three high secure prisons are using this as a pilot programme, along with 'no force first', with a view to the other high secure prisons using the programme if it is successful. Training has been provided to the other two high secure hospital sites in the use of the HOPE(s) and barrier to change checklist.

We reviewed the use of seclusion, long term segregation and reducing restrictive practice. We found that some patients (19 in high secure services) had crisis plans with advance statements in place for voluntary confinement. This meant that if a patient was in crisis, they could request to lock themselves in their room so that they could calm down and prevent any episode that might result in self-harm or harm to others. The patient was allowed to leave the room on request. The trust considered this did not meet the definition of seclusion in the Mental Health Act Code of Practice, as the patient was not prevented from leaving the locked room. If staff felt that the patient should not leave his room when he requested to do so, then they would initiate an episode of seclusion. We had some concerns about the possibility that patients may be prevented from leaving their rooms during the period of voluntary confinement, for example if nurses were not immediately available to review and unlock the door. However, we saw

staff responding promptly during the inspection. All of the patients we spoke to about voluntary confinement told us that they found it helpful as it gave them more control and involvement in their care.

We found seclusion records and long term segregation records to be comprehensive and meeting the Mental Health Act Code of Practice. We interviewed patients detained in long-term segregation, and one patient who was unhappy about his treatment at Ashworth has had his complaint forwarded to the Care Quality Commission Mental Health Act complaints manager for consideration. Most of the patients in long-term segregation who were interviewed had no complaints to make.

There was good use of observations in the service, with the use of observations ranging from general observations up to arm's reach observations. There was a search policy (due for review in May 2018), that clearly outlined the circumstances under which patients, their rooms and possessions could be searched. We saw evidence that this was being adhered to. The trust was using hand-held technologies to support the capture of observation information, this information was used to decrease the level of observations of patients.

Staff we interviewed had a good understanding of safeguarding procedures, and safeguarding training was undertaken by all staff. The teams had made 64 safeguarding adults referrals and one child referral to local authorities between 1 January 2016 and 31 December 2016. March 2016 and July 2016 recorded the most adult referrals in the 12-month period, both with 10 each. In March 2016 eight of the 13 wards made an adult referral versus July 2016 where four of the 13 wards made a referral, with Johnson ward referring the most adults with four in that month. In the 12-month reporting period, the high secure services were referring on average five adults per month, up until 31 December 2016. There was a single child referral, which occurred in April 2016, this was for Gibbon ward.

We looked at 101 medication records during the inspection of the service. The service used the electronic prescribing and medicines administration computer system. It was the first service in the trust to use the system, which had been in use since September 2016. Medication management was safe for patients and staff within the service. We found medication storage to be clean, medication was in date, and clinic rooms were temperature controlled. Fridges

Are services safe?

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used to store drugs were also monitored accordingly. Medicine cupboard keys were held by relevant staff, and there was effective monitoring in place when the keys were handed over.

Some anti-psychotic medication, such as clozapine, was administered through a nasogastric tube or by intramuscular injection for certain patients. We reviewed this practice and considered it to be safe and effective. We checked rapid tranquilisation observation records and found them to be in order.

There were safeguarding procedures in place for visits to the hospital by children, visits taking place in the Exchange building within the secure perimeter. A safeguarding operational group considered safeguarding of children as well as adults, and had a trust lead for children safeguarding in the group. There was also a safeguarding children and adults action plan that had been implemented and reviewed in December 2016.

Track record on safety

Between 1 November 2015 and 31 October 2016, high secure services reported 88 serious incidents, which required investigation. 'Disruptive/ aggressive/ violent behaviour' (16%, 14 incidents) were the most prevalent incident reports.

The Chief Coroner's Office published the local coroners' "reports to prevent future deaths" report. This contained a summary of recommendations, which had been made by the local coroners with the intention of learning lessons from a cause of death and preventing deaths. The trust advised that they did not have any prevention of future death reports in the 12 months prior to inspection, and records showed they had had none since October 2013.

Reporting incidents and learning from when things go wrong

We spoke with staff regarding the reporting of incidents, and all staff knew how to make a report and what constituted a reportable incident. The service used the datix system and another electronic patient record system for reporting incidents, although only registered nursing staff could access the secondary system for this purpose. Reports were collated within the system and then shared and investigated within the team framework, depending on the severity of the incident.

In the period 1 March 2016 to 28 February 2017, there were 4181 datix incidents reported across the 13 high secure

wards. Arnold ward and Tennyson ward had the highest number of reported incidents with 739 and 723 respectively. Forster (Newman) ward and Ruskin ward had the lowest number of reported incidents with 47 and 66 respectively. Of the 4181 datix incidents, 3912 were found to have no injury or harm involved. Only eight of the incidents reported across the 13 wards were classified as serious harm incidents.

The staff on Owen ward identified that many of the incidents reported by their ward staff occurred around the serving hatch in the dining room, when patients would be in close proximity to each other. Issues of personal cleanliness or habits could result in conflict whilst getting food through the hatch. As a means of diverting the problem, Owen ward staff now serve the patients their meals when they are seated, limiting the possibility of clashes. The staff reported that the number of incidents had decreased.

Learning bulletins were regularly issued that contained aspects of investigations that could be used to improve the service. Quality practice alerts were also issued, again with a view to improving the service from incident investigations.

There were structured debriefings dependent upon the level of incident. We were told that, for a category B, or serious, incident, the responsible clinician (consultant psychiatrist) would lead the debrief with a post incident review, with seven day reviews and updates on the findings after that.

Duty of Candour

The trust had a duty of candour policy. The director of patient safety was responsible for ensuring that the duty of candour policy was implemented across the trust on a day-to-day basis. The patient advice and liaison service manager was the operational duty of candour lead, and acted as the family liaison manager for many incidents. That manager was the point of contact for the patient or carer, and liaised with investigators to ensure the family were kept fully informed.

All incidents identified as causing severe or moderate harm or death met the threshold for duty of candour. The duty of candour lead contacted the patient or carer within agreed timescales and offered an initial apology. A follow up letter was provided which included a description of the role of the family liaison manager.

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Weekly surveillance meetings monitored the implementation of duty of candour activity and ensured that due process was adhered to. Divisions supported the decision making process and provided the investigation teams and reports. The trust's duty of candour lead ensured that investigation reports were shared with the patient and carers and that as far as possible the questions they raised were answered fully. All aspects were outlined in the policy "Being Open: duty of candour" policy.

Direct support and guidance for staff was provided by the patient advice and liaison service manager and director of

patient safety when staff were engaged with bereaved families or those affected by a serious incident. The quality assurance committee, on behalf of the trust board, reviewed information on how the trust was complying with duty of candour legislation.

A carer told us how they had been kept informed when an incident occurred, and the lengths to which the service had gone to ensure that all relevant information was dealt with in a proper manner.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

We reviewed 87 care records across the 13 wards in the service, and found that they were generally comprehensive, holistic, and up to date. Initial assessments were completed shortly after admission, to reflect the change in environment and approach required to get the most out of the service. Records showed that there was a multi-disciplinary assessment, with input from various members of the team. Physical healthcare was monitored and fully considered in care records. Patients with significant healthcare conditions were routinely monitored and reviewed. We saw evidence of annual and physical health care checks in care records. The medical centre situated within the secure perimeter, and overseen by a GP, ensured good on site physical healthcare, with access to specialist services should the need arise.

We saw evidence that most care plans were individualised, with input from patients recorded within the plans. Not all care plans were individualised, as it was clear from some plans that patients were not amenable to active involvement in their care. The impact of the HOPE(s) model was reflected in crisis plans to support patients and the self-management of their care.

Care plans and records for patients were stored on the trust's electronic recording system. The system was secure, and accessible to staff with the right levels of computer access. Paper records were minimised, with most patient care recorded on the electronic system.

Best practice in treatment and care

It was clear from records and talking with staff that established guidelines from the National Institute for Care and Health Excellence (NICE) were in place. The definition for rapid tranquilisation was taken directly from guidance relating to violence and aggression (NG10). Medication prescribed above recommended levels was recorded on medication charts in the electronic prescribing system, as stated in guidance on medicine management. National Institute for Care and Health Excellence guidance in relation to caring for people with a personality disorder was noted on Keats ward.

The trust had invested in psychological input, and this was reflected in the number and types of psychological therapy available. We attended multidisciplinary team meetings

where psychologists were actively discussing and arranging therapies such as cognitive behavioural therapy, emotional management work, supportive psychotherapy and schema therapy. The clinical approach was underpinned by the recovery model. This model allowed an environment designed so that patients had primary input over decisions about their care. A Recovery College was available to patients who met the risk assessment criteria for enrolment. We saw evidence on Keats ward of monthly visits to the Recovery College by patients. The courses were individually designed to assist recovery, improve wellbeing, and give patients information about their symptoms and how to control them. We spoke to patients about the psychological therapies available, and one patient told us that for the first time in 14 years he felt he knew what his problems were and how best to deal with them.

There was a medical centre located within the hospital that provided full physical health monitoring and interventions, specialist advice and referrals. This included a dental service. There was access to information regarding aspects of physical healthcare such as smoking cessation and dietary information.

The service used a number of rating scales to assess and record severity and outcomes, such as the Health of the Nation Outcome Scale (HoNOS), the historical clinical risk management (HCR-20) scale, and the Tilt high risk rating for patients in high secure service environments.

High secure wards had participated in five audits between 1 March 2016 and December 2016: cardiovascular disease; management of stable angina, chronic obstructive pulmonary disease, and hypertension audit; diabetes; nutrition support in adults and the management of obesity; termination of seclusion and long term segregation ; and well man's audit. Staff participation in clinical audit was noted across the service, including auditing care plans, infection control, quality review visits, and environmental audits; we saw evidence of this on Arnold ward. There were audits for the prescribing observatory for mental health (POMH) relating to Lithium use, as well as medicine bulletins issued on a monthly basis for feedback, outlining issues relating to medication that had occurred within the trust as a whole.

Ashworth Hospital has the only dedicated research centre in the United Kingdom based within a high secure psychiatric facility. The centre is partnered with a local university, and research was steered by a multidisciplinary

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committee from different fields at Ashworth. Work relating to the introduction of the no force first initiative at three high secure prisons has been undertaken, with a view to five other high secure prisons accepting the programme on completion of a successful pilot.

The trust developed a way of collecting clinically meaningful observation data to assist clinical decision making, leading to a patient uptake of meaningful activity that had risen to 28 hours between March 2016 and March 2017.

Skilled staff to deliver care

The trust target for supervision was 90% of staff to be seen within a rolling six-eight week window. At high secure services, clinical supervision for non-medical staff ranged from 77% to 92% across the 13 wards from the period 1 January 2016 to 1 January 2017. We spoke to staff who told us that they regularly received supervision, and were actively encouraged to request supervision if they felt it was required. The clinical supervision rate for medical staff was 100%, with one doctor being revalidated in the same period.

The non-medical appraisal target for the trust was 95%, and for the period 1 January 2016 to 1 January 2017 the appraisal rate for non-medical staff across the high secure service was 94%. The wards with the lowest rates for appraisals were Newman and Keats with 83% and 85% respectively.

Additional specialised training was available to staff in the service, and we saw examples of nursing staff completing nursing degrees, master's degrees, mentorship modules and care certificates. Specialised training was encouraged across the service.

Staff received comprehensive induction training prior to working within the service. We were told by staff that the trust had sent training staff and information technology staff to the wards to help those staff who struggled with using computers. Training included security training, with annual refresher training for the subject. Management of violence and aggression training was also refreshed annually. Staff we spoke with were aware of the security policy and the need for compliance. Most staff knew what relational security entailed, and nursing staff told us that this was often discussed in multidisciplinary meetings.

Staff meetings regularly took place, and we saw minutes from meetings with set agenda items that reflected the

importance of patient and staff safety on the wards. Charge nurses attended group supervision meetings, and nursing staff told us about reflective practice sessions on the wards that were regularly held.

We discussed with ward managers how they dealt effectively with performance issues, and were assured that input from human resources ensured that such matters were dealt with in a considerate manner.

Multi-disciplinary and inter-agency team work

Multidisciplinary teams within the service comprised consultant psychiatrists, junior doctors, occupational therapists, psychologists, pharmacists, social workers, modern matrons, nursing staff, and security liaison personnel. We attended three multidisciplinary meetings, or patient care team meetings (PCTM), and found them to be comprehensive, insightful, and showed staff to be distinctly caring about the patients in the service. These meetings were held weekly. Different aspects of care were discussed, including mental health status, capacity, physical health, medication, and future plans for the patient. The pathway for the patient was identified in the care programme approach and the consultant psychiatrist ensured the patient was aware of the aims and direction the treatment was designed to follow.

We observed four handovers, each of which was recorded, and the information shared was comprehensive and appropriate. Staff told us that the information they received at handover had to be precise or it could result in a lapse in safety for a patient or staff. The movement of staff between wards due to safe staffing issues meant that often a staff member could be moved to a ward they were not familiar with, therefore a comprehensive handover was vital to ensure that staff were aware of the needs of the patients they were working with.

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

Mental Health Act training was included in mandatory training for the trust. Training figures regarding the Mental Health Act were requested from the trust. However, the data showed that fewer than three per cent of staff had completed the training. On checking the data, it referred to Mental Health Act/Deprivation of Liberty Safeguards training. On site data showed that, the 13 wards in the service were pushing mandatory training forward, and Mental Health Act training in particular. On Carlyle ward, 19 of 21 staff (90%) had completed the training. On Dickens

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ward, only 55% of staff had completed the training. On Lawrence ward, 97% of staff had completed mandatory training in the Mental Health Act. On Tennyson ward, 92% of staff had completed the training.

Staff we spoke to had a good understanding of the Mental Health Act and the Code of Practice, and the guiding principles. The Mental Health Act policy, which was due for review in October 2017, referred to an out of date Mental Health Act Code of Practice.

We saw that consent to treatment and capacity requirements were adhered to. We saw that rights were explained to patients at appropriate intervals, and were recorded both in patient notes and on boards that were maintained in the main office of each ward. The Mental Health Act administrator audited rights and issued a report that used red, amber and green colours to indicate the necessity to explain rights to a patient.

We found that a form regarding the provision of information to detained patients was being incorrectly used. The form had a tick box that referred to the power of the responsible clinician, hospital managers and the nearest relative to discharge a patient. Staff had routinely been ticking the box, which indicated this had been explained to the patient. However, as the patients in high secure services are restricted patients, it was not the decision of the consultant, the hospital or family to grant discharge. We discussed this with the trust, and they immediately re-issued the form with a disclaimer in red ink that showed that this particular section was not applicable to restricted patients.

We reviewed long term segregation to ensure that patient rights were being adhered to under the Mental Health Act. We found that the patients in long term segregation were reviewed on a daily basis in all cases. There was a segregation nursing care plan that was up to date and comprehensive. Each patient had a segregation planner with planned activities that were offered to the patient, and medical reviews were routinely carried out. There was evidence of medical and independent reviews taking place when required.

During the inspection, some patients and carers told us that their care under the Mental Health Act was not being

properly considered. In each case we looked into the complaints and sought instruction and guidance, and concluded that the trust were acting in the best interests of the patients.

We found that detention paperwork was completed accurately. There was access to advocacy in the service, with the advocacy service having been taken over by a new provider just prior to inspection.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was mandatory for staff. They were expected to repeat the training every three years by electronic learning. Data provided to us by the trust showed compliance in Mental Capacity Act training at 30.7% across the trust. However, in high secure services we saw evidence of ongoing training in mental capacity. On Lawrence ward, 98% of staff had had training in the Mental Capacity Act, 89% on Tennyson ward, and 95% on Carlyle ward. However, the rate on Dickens ward was only 50%. A training action plan for January 2017 showed that the figure of 88% had been achieved trust wide. The drive to improve Mental Capacity Act training and monitoring the results fell to the law governance group for the trust.

Staff we spoke with had a good working knowledge of the Mental Capacity Act, and some staff carried small folding aide memoires that outlined the principles of assessing capacity.

We saw evidence in care plans and in records that capacity was being considered appropriately. Decisions as to physical health care were seen to be considerate of capacity. We case tracked one particular case due to the extreme nature of the circumstances, but were assured by findings that the trust had acted in line with the principles of the Act.

We saw that best interest meetings had taken place where necessary. Social workers attached to wards and attending multidisciplinary team meetings provided additional support and assistance if required. Deprivation of Liberty Safeguards did not apply to this service, as all patients were restricted/detained.

There was a Mental Capacity Act knowledge audit carried out in February 2017, in which 40 staff were interviewed and asked a range of questions regarding the Act. All staff who took part in the audit had some or good knowledge and understanding of the Mental Capacity Act and many

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could identify all or most of the principles. Some staff showed confusion between the Mental Capacity Act and the Mental Health Act. The audit concluded that there should be additional training in the Mental Capacity Act.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 62 patients in the service. Most patients we spoke with were positive about their care. One patient told us that he had a back problem, and that he had access to pain relief when needed and regularly saw a doctor. We spoke with a patient using an interpreter in his own language. A patient stated that the trust had provided him with books in his own language, but he was not particularly happy with the food being served: he had no special dietary requirements for health or religious reasons.

We received eight comment cards regarding high secure services. Two were positive in nature, three were negative, two cards were mixed and one card was unclear. Staffing levels were mentioned in the cards, all suggesting more staff were needed on the wards. There was mention of problems with medication management on a ward. We included a review of medication management practice in the inspection and found nothing untoward occurring on the ward.

We saw many examples of good interactions between patients and staff. We observed a shopping trip from Gibbon ward, with staff and patients going to the onsite library and shop, and observed positive and supportive interactions between staff and patients. Patients who worked in the shop said they found working there therapeutic. We observed a patient forum and noted that agenda items were listed by the patients, and led by a patient service manager. The forum briefed patients on current staffing levels in the service, and about staff training for April 2017. Activities were discussed, and patients had an opportunity to have meaningful input into the way activities were being run. We observed staff handovers and multidisciplinary team meetings that showed understanding and knowledge of the patients in their care.

We spoke with patients who specifically requested to speak with the inspection team. Historical concerns were raised, such as treatment in previous services, and feelings that concerns were not being considered properly. We tracked care records relating to some of these patients and found no major concerns with the actions of the service. A patient raised concerns about a possible move back to the prison service: we reviewed decisions made on the behalf of the patient and found them balanced and fair.

Patient-led assessments of the care environment (PLACE) assessments are self-assessments undertaken by NHS and private or independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy, dignity and wellbeing, the 2016 PLACE score for Ashworth Hospital was 86%, which was worse than the England average of 90% and the trust score of 91%.

The involvement of people in the care that they receive

Patients at the service were given a welcome pack that outlined the ward the patient was being admitted to. Each patient had an assessment prior to admission, with at least one visit to the ward. A named nurse spoke with the patient by way of introduction. Each ward had a patient representative who attended patient forums on behalf of the ward. We spoke with a patient representative, he spoke about the responsibility he felt towards his fellow patients, and stated how he was listened to by staff at forums. We observed a monthly patient forum, and were impressed with the level of engagement and response that patient representatives received. A copy of the minutes of each patient forum was assigned to each ward and put on a noticeboard for patients to read.

Feedback to the service was clearly accessible to patients. The restrictive practice monitoring group met every month, and an important aspect of their meeting was to view patient input. We were told by the lead of the reducing restrictive practice group that the trust's 'no force first' policy was designed with the help of patients.

Each ward had a community meeting that patients were encouraged to attend. The notes from the meetings were displayed on the wards, so were available for patients who had not attended.

Care records showed that patients were involved in decisions about their care. The recovery star model of treatment actively involved patients in setting goals and targets to take them forward. We saw notice boards that had information about different treatments available to patients. On Owen ward there was lots of information regarding the recovery college, patient experience, religious access, information technology education, advocacy access and safeguarding information. This was reflected on other wards within the service. We saw evidence of patients

Are services caring?

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being able to video link with family who struggled to travel to visit their relative. A new advocacy provider had recently joined the trust, and records showed evidence of advocacy input.

Doors on refurbished wards had privacy screen windows, requiring a key to enable viewing into a room, thereby giving some privacy and dignity to patients. Wards awaiting refurbishment used curtains across the door window to maintain privacy. We saw evidence of advanced decisions being in place for patients, with appropriate care planning in records.

We contacted three carers of patients who had agreed to speak with us. They were generally positive in their

comments about the service. The carers indicated that their input into the care of their relatives in the service had increased in recent years, and one carer felt that they were afforded excellent contact at all levels of the trust if they so wanted it. During the case tracking of one patient, we spoke with their carer who was less positive about the service and the trust.

We held a carer forum prior to the inspection. The carers who attended gave very positive feedback regarding the treatment of their relatives. Carers told us that they were actively involved in the treatment of their relatives, and felt that the trust was doing the best for their relatives.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

The national target for high secure services for 'referral to initial assessment' was 21 days when in receipt of all information and 'from assessment to initial treatment' the national target was 168 days. The high secure service met all national targets for referral to initial assessment and assessment to treatment. Tennyson ward met all targets, however their days from assessment to treatment was reported at 92 days, which was the highest of all the wards listed for the service.

Twelve of 13 wards had bed occupancies of 85% and above. Shelley ward achieved below the 85% national benchmark for the full year, scoring between 56% and 80%, with December 2016 scoring their lowest with 56%. Owen ward scored below 85% for eight of the 12 months, however between October to December 2016 their bed occupancy went over 90% every month. The high secure wards with the highest average bed occupancies were Newman (114%), Lawrence (112%) and Gibbon (111%). Newman (Forster) ward reported their highest bed occupancy levels for four months (May to August 2016), reporting 120% for each month. They fell by five percentage points to 115% in September 2016 and then another five percentage points to 110% in October 2016, whereby the team had been consistent at 110% until December 2016. Lawrence ward had been reporting consistently above 100% for the 12 month period, ranging from 102% to 118%. In December 2016 Lawrence ward reported 117% bed occupancy, which was the highest across the high secure wards for that month. A ward could have higher than 100% occupancy due to the use of seclusion rooms on the ward for patients from another ward.

In the 12 months prior to inspection, there were no recorded movement of patients between wards after 10 o'clock at night. There were 40 discharges from high secure services of which seven were delayed discharges. A delayed discharge is when a patient no longer requires a high secure bed, but cannot move on due to an appropriate placement not being available. The wards with the highest numbers of delayed discharges were Gibbon and Shelley with two each. There were no instances of out of area placements or readmissions within 28 days reported for high secure wards.

Between 1 January 2016 and 31 December 2016, discharged patients had lengths of stay ranging from 113 days to 3,349 days across nine of the 13 wards. Ruskin ward had the highest average length of stay across three of the 12 months with 5,134 days. Arnold ward had the lowest average length with 113 days.

Internal referrals from ward to ward were dealt with, on average, within a week, dependent upon bed availability. This involved the assessment of each patient for their suitability to move to another ward with a higher or lower level of dependency.

The facilities promote recovery, comfort, dignity and confidentiality

The 13 wards visited during the inspection varied in standards of decoration and equipment. Newman ward had been recently refurbished and had only been open for a week; the finish of the ward was modern and fresh. The wards were refurbished on a rolling basis, ensuring that the older wards were improved over time.

Each ward had a clinic room that allowed for the examination of patients and monitoring of physical health care, including an examination couch, weight and blood pressure levels. The clinic rooms were clean and equipment was monitored and recalibrated if necessary.

The wards had a variety of rooms in order to facilitate activities. This included gym equipment, full size snooker tables, television and music rooms. Some wards had monitored computer access for patients. Each ward had a large lounge area with comfortable chairs. The lounge area included a lockable storage area for each patient. Patients could keep items such as dry foods in these lockers. There were two interview rooms on each ward that could be used for visitors to the ward, dependent upon individual circumstances. However, most visits took place in the Exchange building within the secure perimeter. There was a stringent security policy in place for visitors to the service.

Patients were not allowed access to personal mobile telephones. Each ward had a telephone room for patients. Patients were able to make calls to their own list of approved numbers. This included the telephone number of the Care Quality Commission. Monitoring of patient telephone calls was included in risk assessments after discussion with security personnel. Patients had the right under the Mental Health Act to challenge any such decision. Authorised members of staff could record a

Are services responsive to people's needs?

Good 

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random 10 per cent of telephone calls of patients, with the power to listen to those calls. Patients in long term segregation could have a telephone taken to the door hatch.

Each ward had an outdoor space for patients to use. Patients were individually risk assessed to access these areas. However, patients were also considered for grounds access. We saw patients walking around the areas between wards.

Feedback regarding the standard of food was mixed, but generally positive. Food quality was an agenda item in patient forums. The minutes from the patient forum on 22 March 2017 showed that patients were concerned that food was either too hot or too cold. An action to remind staff how to use the temperature control on food trolleys was agreed and action taken. The patient led assessment of care environments survey for 2016 showed that in relation to food, Ashworth Hospital scored similarly to both the overall provider level score and the England Average (92%). When comparing scores with those achieved for food in 2015 (86%), Ashworth Hospital saw an increase in their score in 2016 by six per cent (92%). Some wards allowed patients to prepare their own food, and drinks and snacks were available at all times. Halal and kosher food was available to patients who required it.

Patients could access their bedrooms at all times during the day, unless access was curtailed due to care planning. Rooms were comfortable, there were rules on how much clothing patients could have in the rooms, but they could personalise rooms with pictures and photographs. There were storage rooms for patient property.

Meeting the needs of all people who use the service

We saw that individual needs regarding physical health care were discussed with patients; on Carlyle ward the expert by experience in the inspection team noted a staff member discussing diabetes and nutritional care with a patient, the staff member was noted to be knowledgeable and understanding of that patient's needs.

In June 2015, an 'accessible information standard' was approved by NHS England: organisations should ensure that disabled patients and, where appropriate, family and carers receive information in formats that they can understand. The trust had a policy that reflected this standard, as well as a secure services equality and human

rights action plan that stipulated full implementation of the accessible information standard. The trust Carer's policy also reflected the need for accessible information. We saw medication information leaflets designed for patients and families that were designed to be easy to read. The useful information guide for patients outlined rights and expectations, using pictures to denote different aspects of the information.

Access to the secure service was designed with disabilities considered. Entrances to wards were flat and wide, and wards were on one floor. Bathrooms had equipment to assist people with physical problems. Staff members with disabilities or mental health needs were considered, with recent proactive changes to human resource policies after a review by the trust equality lead. A national staff health and wellbeing commissioning for quality and innovation (CQUIN) was in place, with physiotherapy, mental health, physical health and mindfulness courses and activities for staff.

Noticeboards on the wards had information regarding rights and treatments. Access to information in different languages was available using the trust intranet to download information and print it off for patients. Interpreters were frequently used: a patient who had an interpreter with him told us that he was provided with information in his own language.

Religious needs were met in the service, with a chapel being available within the secure perimeter. Patients had access to Roman Catholic and Church of England clergy, as well as an Imam for Muslim patients. Some wards utilised a room as a multi-faith room.

Listening to and learning from concerns and complaints

All of the patients we spoke with stated they knew how to complain, as did the carers we contacted. We saw complaint forms on each ward, and access to information on how to complain was available to all. The Care Quality Commission telephone number was added to the telephone list of every patient, should they want to complain to the organisation. Patients were also directed to the patient advice and liaison service for the trust. On Arnold ward we saw that an advocate attended community meetings in order to ensure that complaints were fairly heard. Complaints were identified as either formal or informal. Informal complaints were usually dealt with on

Are services responsive to people's needs?

Good 

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

the ward, unless the patient was not satisfied with the outcome. Formal complaints were dealt with through the trust's formal complaints procedures, and investigated by an appropriately trained member of staff.

The trust aimed to deal with complaints within 25 days, as per their complaint policy. There were a number of factors that affected the ability to close complaints down in under 25 working days. This included the allocation to an appropriate reviewer; the complainant being too unwell to meet with the investigator; the complex nature of a complaint and the need to interview several members of staff; and the thorough checking process and scrutiny of investigation reports.

High secure wards received 326 complaints during the period 1 January 2016 to 31 December 2016. Of these 326 complaints, 52 (16%) were upheld, 41 (13%) were partially upheld and one was referred to the ombudsman. The

ombudsman is still investigating this complaint. The primary reasons for complaints included: 'other' with 77 (24%), 'attitude of staff' with 65 (20%), 'patients' property and expenses' with 55 (17%), 'hotel services (including food)' with 42 (13%), 'all aspects of clinical treatment' with 21 (13%), 'communication/information to patients (written and oral)' with 14 (4%) and 'policy and commercial decisions of trusts' with 11 (3%).

High secure wards received three compliments during the time-period 1 January 2016 to 31 December 2016.

Learning from complaints was fed back to the teams in a number of ways. Learning bulletins were issued regularly to wards for staff to be kept informed. Staff meetings were used to share learning from complaints. Wards used a "you said we did" notice to keep patients informed of changes made after complaints or requests.

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Good 

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Our findings

Vision and values

We spoke with staff regarding the vision and values of the trust, and all staff spoke knowledgeably regarding the subject. Staff quoted continuous improvement, accountability, respect and enthusiasm (CARE). We saw evidence throughout the wards of team values being displayed on noticeboards for both staff and patients to view.

Staff we spoke with could name senior management team members. Matrons attended the wards each day, and took part in multidisciplinary team meetings and other forums. Staff told us that the executive director for nursing was a frequent visitor to the wards, and would talk with staff and patients. The ward manager stated that he would actively seek senior personnel to visit the ward, as he felt it was a necessary aspect of his role to ensure senior personnel were involved in patient care.

The chief executive of the trust had initiated programmes such as “breakfast with Joe”, where a staff member had breakfast with the chief executive in their birthday month, which gave staff the opportunity to talk with the chief executive in a frank and open manner. The chief executive also had a blog and an email address that allowed anyone to contact him about any troubles or concerns they had.

Good governance

Drawing on evidence from the other domains, we were assured that there was an effective governance system in place for high secure services. We saw that staff received mandatory training, although figures drawn from ward records were more accurate than those submitted as data requests from the trust.

Supervision and appraisal is an on-going programme within the service, and was found to be up to date at all levels.

Staffing issues were dealt with by the safe staffing system, and ward managers adjusted staffing levels to meet the needs of the service at any given time. Patients and staff told us that the service was short staffed. The trust had an on-going recruitment policy that aimed to recruit more staff than were needed. This is due to the knowledge that staff turnover is a constant, and extra staff would allow cover for duties.

We saw evidence that staff maintained patient contact as well as their administrative duties. Staff engagement with patients was excellent, it was clear that staff knew patients well and this was reflected in the depth of handover information on the wards. Patient one to one time was recorded in care records.

There was evidence of participation in clinical audit. Audits included infection control, care plans, and observations. This allowed staff to be aware of situations or aspects of ward work that required improvement or were going well.

Incidents were being reported on the wards. This was shown by data that reported 4181 incidents had been recorded on the datix system in the period 1 March 2016 to 28 February 2017. We saw evidence that learning was fed back to the teams following incidents.

Mental Health Act and Mental Capacity Act procedures were followed. However, the current Mental Health Act policy contained references to the previous Code of Practice, and required updating.

The service used key performance indicators to gauge the performance of the service, and used the data services to identify weaknesses and strengths. These included risk assessments, care programme approach, treatment and activity, staff development, and physical health care. Treatment and activity data showed that in December 2016 mental health patients in high secure were averaging almost 29 hours a week of completed therapeutic activity, and personality disorder patients were averaging 30 hours a week. This compared favourably against the trust and national target of 25 hours. The dashboard was easy to read, and was available to ward managers to guide staff and treatment.

We asked ward managers if they felt that they had sufficient authority to do the job they wanted to do, and the replies were very positive. They cited recent changes allowing them to manage staff shortages and the support of their senior managers as being key to the running of their wards. Ward managers told us they had access to administrative support, and this helped free their time for patient facing activities.

Staff could submit items to the trust risk register, by raising the points with their manager. At the time of inspection, the trust risk register had 12 items relating to high secure services. The items mostly accepted and monitored possible scenarios, such as the effects of a patient

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accessing a rooftop, a door being left open, or the smuggling in of mobile telephones. Some items had been on the register since 2011, but were reviewed annually. Five of the items related to good governance, and all five had a better current risk rating than when initially placed on the register.

Leadership, morale and staff engagement

We saw that wards were well led by ward managers. Nursing staff spoke highly of their managers, although there were some concerns raised about the frequency of movement of ward managers between wards. We were told that there had been three managers on Dickens ward in as many months. The current ward manager had been there for three months, the ward manager on Owen ward had only been in post three days. Staff were happier with the increased input of psychologists and occupational therapists, and felt that this added to the effectiveness of the treatment on the ward. Modern matrons were praised by the staff, they felt that the matrons took an active role on the wards, and were present most days.

Data showed that staff sickness on the high secure service wards in the period 1 January 2016 to 31 December 2016 ranged between 19 per cent on Keats ward and Ruskin ward, and four per cent on Blake ward. Keats and Ruskin wards had staff leaving rates of 19% and 18% respectively; this could have impacted on sickness rates. Since 17 January 2016, there had been two members of staff suspended from duty in high secure services, with one of those staff members already returned to work.

We were told by staff that they were aware of how to raise concerns, and felt comfortable in doing so. At the time of the inspection, we were not aware of any bullying or harassment cases ongoing within the service. Staff were asked about the whistleblowing process, and they were mostly knowledgeable.

Staff did not mention fears of victimisation if they raised concerns. Staff felt that they were listened to by managers, and their opinions and insight counted. Most of the staff said they were happy with their job, and felt they were empowered. Some staff said they would be happier if they could spend more time with patients rather than doing paperwork. While there were opportunities for leadership development for managers, ward staff did not feel there were enough opportunities for them.

Staff knew of the duty of candour in dealing with patients, and felt that they had always been open and transparent with patients if things went wrong. We were told that staff had the opportunity to give feedback into services through channels such as team meetings, and supervision and appraisals. There was a trust initiative called “your voice your change”, where staff would be given the opportunity to talk freely and put forward concerns and ideas. There was a morning meeting, rotated between wards, which was attended by the modern matron, the duty manager, and the head of social care. Staff were invited to give feedback, and the minutes of these meetings were circulated. Staff spoke about weekly communications and requests for feedback, as well as staff questionnaires and staff forums.

Commitment to quality improvement and innovation

We saw ongoing evidence of commitment to improvement and innovation. The use of the positive intervention programme service (PIPS) team was observed assisting on wards. The team directed staff in the best practice in the movement of challenging patients, and empowered staff to carry out the work without relying on the team to do it for them.

The reducing restrictive practice group was working towards ensuring best practice was carried out not just in the service, but across high secure services elsewhere, especially with patients in long term segregation. The HOPE(S) clinical model developed within Ashworth hospital in 2015 has been piloted at three high secure prisons across the country, with a view to the remaining five high secure prisons adopting the model if the pilot is successful.

The no force first policy was introduced to Forster (Newman) ward on 6 January 2015, with the policy finally embedded service-wide with introduction in Blake and Tennyson wards in April 2016. There were 34 restraints recorded after the policy was finalised in April 2016. Data provided by the trust showed a marked, consistent decrease in the number of restraints in the period 1 January 2016 to 31 December 2016.

The annual prison service audit of high secure services completed in January 2016 achieved 100%. This was the first time this had been achieved by a high secure hospital.

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Ashworth hospital was the only high secure hospital in the country with its own research centre in the grounds of the secure perimeter.