

Oxleas NHS Foundation Trust

# Forensic inpatient/secure wards

## Quality Report

Pinewood House  
Pinewood Place  
Dartford  
Kent  
DA2 7WG  
Tel: 01322625700  
Website: [www.oxleas.nhs.uk](http://www.oxleas.nhs.uk)

Date of inspection visit: 24 - 26 April 2017  
Date of publication: 06/07/2017

### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RPGAB	The Bracton Centre	Danson Heath Joydens Crofton Birchwood Burgess	DA2 7AF
RPGXA	Greenwood and Hazelwood	Greenwood Hazelwood	SE18 3RZ

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

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

# Summary of findings

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

Outstanding 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated forensic inpatient/secure wards as **good** because:

- At the inspection in April 2016, we found that the pre-discharge ward, Birchwood, sometimes had only one staff member on the ward. At the current inspection we found there were at least two staff members on Birchwood at all times. Nurse staffing levels had also been benchmarked with other forensic services. This had resulted in an increase in nursing posts.
- During the April 2016 inspection, ligature risk assessments were not undertaken for all ward areas. We found plastic bags on the wards. Plastic bags were on the list of banned items for the wards. Risks within the service had not been addressed effectively. At the current inspection, ward ligature risk assessments included all areas of the wards. There were no plastic bags on the wards. There had been significant improvements to most wards by the installation of parabolic and convex mirrors. These enabled staff to see 'blind spots' on the wards. The trust had responded in a timely and effective manner to a range of risks that had been highlighted in the previous year. The senior management team were focussed on risks in the service.
- During the April 2016 inspection, we found that the trust had not followed the Mental Health Act Code of Practice in a number of areas. The seclusion room on Heath did not meet Code of Practice guidance. A number of patients were not routinely advised of their rights in accordance with section 132 of the Mental Health Act. Patients' ability to understand and consent to treatment was not recorded in detail. Patients were not routinely given copies of their section 17 leave forms. At the current inspection, the seclusion room on Heath was being rebuilt. Almost all patients were regularly informed of their section 132 rights. Patients' capacity to consent to treatment was recorded in detail and patients had copies of their section 17 leave forms.
- In April 2016, following changes in the use and purpose of Joydens and Heath, some female patients were waiting to be assessed to determine which level of security would best meet their needs. At the current inspection, all female patients had been assessed and were on the appropriate wards. The same consultant psychiatrists and psychologists worked on Heath and Joydens. This provided continuity of care for patients when they changed wards. This was particularly important for women who had a poor experience of relationships with others.
- At the April 2016 inspection, we found that audits did not translate into action at ward level.
- At this inspection, Crofton had piloted the use of the Broset violence checklist (BVC). This is an easily understood tool to predict increasing levels of patients aggression. Part of this pilot involved an audit, which found a 37% decrease in patient incidents after using the BVC. Following the audit all forensic admission wards began using the BVC. Other forensic wards implemented a care zoning tool to reflect patient risks.
- The service was smoke-free, and a smoking cessation clinic operated seven days per week. The fresh air project on Friday evenings involved a meal and a smoking cessation education session. Patients' carbon monoxide readings were also taken. In seven months, 63% of patients had lower carbon monoxide readings. This meant these patients were healthier.
- Occupational therapy staff worked every day of the week and activities took place every day, including bank holidays. There was an exceptional range of individual and group activities during the day and evening. These included cycling, art, bricklaying, literacy and numeracy, sports and exercise groups, a spiritual care group, and design and technology. Patients could gain recognised qualifications and real work opportunities were available, where patients worked for external organisations. This meant they could get work references increasing their chances of future employment.
- A carer's telephone line operated week days to provide support for carers.

# Summary of findings

- Staff felt supported by their immediate managers. Staff were confident to use the whistleblowing procedure and to raise concerns. There was a strong sense of team working and mutual support.
- Improvements meant that forensic inpatient/secure wards were now meeting Regulations 9, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However:

- A number of blanket restrictions and practices were in place across all wards. These included room

searches and patients' use of mobile phones. These restrictions and practices were not specific to the groups of patients on individual wards or the level of security.

- Patients' care plans varied in quality across the forensic services. While some patients' care plans were detailed and person centred others were not. Some did not address all the patients' needs.
- The patients' telephone on each ward had a privacy hood, but these were not effective and did not enable patients to make private phone calls.

# Summary of findings

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

### Are services safe?

We rated safe as **good** because:

- During this inspection, we found that the service had addressed the issues, which had caused us to rate safe as requires improvement during the April 2016 inspection.
- At the inspection in April 2016, we found that two staff members worked on Birchwood, the pre-discharge ward. When a staff member was escorting clients this left one staff member on the ward. At the current inspection we found there were two staff members on Birchwood at all times.
- During the April 2016 inspection, we found that ligature risk assessments were not undertaken for all ward areas. At the current inspection, ward ligature risk assessments included all areas of the wards. Ligature risk assessments included photographs to assist staff with identifying ligature points.
- At the April 2016 inspection, we found plastic bags on the wards, in laundry rooms and bathrooms. Plastic bags were on the list of banned items for the wards. On the current inspection, there were no plastic bags on the wards.
- Crofton had piloted the use of the Broset violence checklist (BVC). This is an easily understood tool used to predict increasing levels of patient aggression. This pilot resulted in a 37% decrease in patient incidents. Following the pilot all forensic admission wards began using the BVC.

However:

- A number of blanket restrictions and practices were in place across all wards. These included room searches and patients' use of mobile phones. These restrictions and practices were not specific to the groups of patients on individual wards or the level of security.

Good



### Are services effective?

We rated effective as **good** because:

- During this inspection, we found that the service had addressed the issues, which had caused us to rate effective as requires improvement during the April 2016 inspection.
- During the April 2016 inspection, we found that the seclusion room on Heath did not meet the guidance set down by the Mental Health Act code of practice. On this inspection, the seclusion room on Heath was being rebuilt.

Good



# Summary of findings

- During the April 2016 inspection, a number of patients were not routinely advised of their rights in accordance with section 132 of the Mental Health Act. On this inspection, overall, we found that patients were routinely informed of their rights.
- The inspection in April 2016 found that patients did not have robust capacity assessments to confirm they were able to understand and consent to treatment. On this inspection, patients had detailed capacity assessments concerning their treatment.
- During the April 2016 inspection, following changes in the use and purpose of Joydens and Heath, some female patients were waiting to be assessed to determine which levels of security would best meet their needs. At this inspection, all female patients had been assessed and were on the appropriate wards.
- The April 2016 inspection found that patients were not routinely given copies of their section 17 leave form. During this inspection, we found that patients had copies of their section 17 leave form.
- The service was smoke-free and a smoking cessation clinic operated seven days per week. At the fresh air project, patients' carbon monoxide readings were taken, followed by a smoking cessation education session and a meal. In seven months, 63% of patients had lower carbon monoxide readings.

However:

- Patients' care plans varied in quality across the forensic services. Whilst most care plans were detailed and centred on patients' needs, some care plans were not, and did not address all the patients' needs.

## Are services caring?

We rated caring as **good** because:

- Most patients were positive regarding staff. They said that staff treated them with kindness and respect and were genuinely interested in their care and wellbeing.
- When patients displayed behaviour which challenged staff, the staff team had 'positive slant' meetings. These meetings reviewed the reasons why a patient may behave the way they do. The 'positive slant' meetings assisted staff to maintain a positive and empathic outlook when caring for these patients.

**Good**





# Summary of findings

- Staff demonstrated a good understanding of patients' needs. During multi-disciplinary team handovers and nursing handovers, staff spoke with insight into patient's needs and preferences.
- A carers telephone line operated week days to provide support for carers.
- When patients were admitted to the service they were given a comprehensive information booklet.
- Almost all patients had a copy of their care plan and this was recorded in their clinical records.
- A carers' telephone line operated week days to provide support for carers. Regular carers meetings also took place in addition to summer and Christmas fairs.
- The service undertook an annual survey of patient views. There were also monthly patient surveys focusing on five questions about patients care and treatment. The patient surveys were used to monitor the quality of care and improve the service.
- Patients attended the social events committee and the reducing restrictive practices meeting. Patients were able to take part in decision making regarding the service.

However:

- On Joydens, patients queued up at the clinic room to receive their medicines. Patients were unhappy with this, and this was not in accordance with best practice.

## Are services responsive to people's needs?

We rated responsive as **outstanding** because:

- Occupational therapy staff worked every day of the week and activities took place every day, including bank holidays. There was an exceptional range of individual and group activities during the day and evening.
- Activities included cycling, design and technology, a rock choir and picture framing. Adult education groups in literacy and numeracy took place leading to recognised qualifications. The activity programme was focussed on patients' strengths and interests and provided patients with a variety of choices.
- Patient activities included bricklaying and horticulture. When patients were discharged from hospital they could return for these activities to gain national vocational qualifications.
- Real work opportunities were available, and patients worked for external organisations. This meant that they could get work references increasing their chances of future employment.

**Outstanding**



# Summary of findings

- The service was starting a forensic recovery college shortly after the inspection. Four courses were planned, three operating for eight weeks and the other for six weeks.
- Two gym instructors worked at the Bracton Centre and the gym was open five days a week. There was also an outside gym in the grounds. Groups included football and boxing, and male and female sports groups. Patients at Greenwood and Hazelwood also had access to a gym.
- The same consultant psychiatrists and psychologists worked on Heath and Joydens. Female patients moving from Heath to Joydens would have the same psychiatrist and psychologist. This was particularly important for women who had a poor experience of relationships with others.

However:

- The patients telephone on each ward had a privacy hood, but these were not effective and did not enable patients to make private phone calls.

## Are services well-led?

We rated well led **good** because:

- During this inspection, we found that the service had addressed the issues which had caused us to rate well-led as requires improvement during the April 2016 inspection.
- During the April 2016 inspection, we found that risks within the service had not been addressed effectively. This specifically related to ligature risks. At the current inspection, we found the trust had responded to a range of risks which had been highlighted in the previous year. Ligature risks were being addressed in a timely and effective manner.
- At the April 2016 inspection, we found that audits did not translate into action at ward level. At the current inspection we found that audits were acted upon.
- When we undertook the April 2016 inspection, we found that the leadership team had failed to act promptly when ward managers highlighted risks. There was a lack of urgency regarding improvements and changes took a long time to implement. At the current inspection, we found that a number of improvements had been made. The senior management team were focussed on risks in the service, and improvements were being made in a timely manner. A number of safety improvements had taken place and were continuing.

Good



# Summary of findings

- The senior management team were aware of areas for improvement and were committed to improving care and treatment for patients.
- The patient safety, clinical improvement and patient experience groups were used to share learning across the wards and to improve the service.
- Staff felt supported by their immediate line managers. Staff were confident to use the whistleblowing procedure and to raise concerns. There was a strong sense of team working and mutual support.

# Summary of findings

## Information about the service

Oxleas NHS Foundation Trust forensic inpatient services are located on two hospital sites: The Bracton Centre in Dartford and Memorial Hospital in Greenwich. The Bracton Centre has six medium and low secure wards. Memorial Hospital has two low secure wards.

The service provides care and treatment to patients detained under the Mental Health Act 1983, and who live in the London boroughs of Bexley, Bromley, Greenwich and Lewisham. The service is for males and females aged 18 – 65 years.

The wards operated by the service are as follows:

The Bracton Centre

Birchwood – A 12 bed male medium secure pre-discharge ward

Burgess – A 17 bed male medium secure admission and treatment ward

Crofton – A 17 bed male medium secure admission and treatment ward

Danson – A 17 bed male medium secure rehabilitation ward

Heath – A 16 bed female medium secure admission and treatment ward

Joydens – A 13 bed female low secure rehabilitation ward

In addition, Kelsey unit is a four bedded intensive care area. This unit is not permanently staffed. If a patient requires intensive care, staff from the patient's ward work on Kelsey.

Memorial Hospital

Greenwood – A 16 bed male low secure rehabilitation ward

Hazelwood – A 16 bed male low secure rehabilitation ward

When we last inspected the trust in April 2016, we found that the trust had breached regulations. We issued the trust three requirement notices for forensic inpatient/secure wards. These related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 9 Person-centred care

Regulation 12 Safe care and treatment

Regulation 18 Staffing

## Our inspection team

The team was comprised of: three CQC inspectors, a CQC inspection manager and three specialist advisors, two of whom were nurses together with a psychiatrist. The team included two experts by experience, who had experience of using similar services.

## Why we carried out this inspection

We undertook this inspection to find out whether Oxleas NHS Foundation Trust had made improvements to their forensic inpatient/secure wards since our last comprehensive inspection of the trust in April 2016.

When we last inspected the forensic inpatient/secure wards in April 2016, we rated the forensic inpatient/secure wards as **requires improvement** overall.

We rated the core service as requires improvement for safe, effective and well-led, and good for caring and responsive.

# Summary of findings

Following the April 2016 inspection, we told the trust it must take the following actions to improve forensic inpatient/secure wards:

- The trust must ensure that patients are, as far as is reasonably possible, protected from potential ligature risks by considering all ward areas when carrying out ligature risk assessments.
- The trust must ensure all staff working in secure services are not left to work alone on a ward.
- The trust must ensure that patients have robust mental capacity assessments to ascertain their consent to treatment.
- The trust must ensure that the service complies with the Mental Health Act Code of Practice (2015) guidance on seclusion rooms.

These related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 9 Person-centred care

Regulation 12 Safe care and treatment

Regulation 18 Staffing

Following the April 2016 inspection, we also made the following recommendations to the trust to improve forensic inpatient/secure wards:

- The trust should ensure that staff record when they offer patients a copy of their care plan.
- The trust should ensure that patients are routinely informed of their rights under section 132 of the Mental Health Act, in line with guidance laid out in the Mental Health Act Code of Practice (2015).
- The trust should ensure that patients are given a copy of their section 17 leave forms, in line with guidance laid out in the Mental Health Act Code of Practice (2015).
- The trust should ensure they comply with their own policy on banned and restricted items.
- The trust should ensure that all staff received regular training and updates on the Mental Health Act Code of Practice (2015).

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked commissioners for information.

During the inspection visit, the inspection team:

- visited all eight of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 54 patients who were using the service

- spoke with the managers or acting managers for each of the wards
- spoke with 32 other staff members; including doctors, nurses, psychologists, occupational therapists, support workers and a housekeeper
- interviewed the service director and clinical director with responsibility for these services
- spoke with a general practitioner visiting the wards
- attended and observed two handover meetings, a multi-disciplinary handover meeting and a ward round
- attended and observed a 'positive slant' staff reflection meeting and a ward community meeting
- looked at 23 treatment records of patients
- looked at five staff supervision records
- undertook three Mental Health Act visits of wards immediately prior to the inspection

# Summary of findings

- reviewed the medicines management on five wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

The trust was informed of the inspection on the working day prior to the inspection.

## What people who use the provider's services say

Most patients were positive regarding staff. They said that staff treated them with kindness and respect and were genuinely interested in their care and wellbeing. Patients

reported that staff were fair and caring. Some patients gave praise to particular staff members. However, a small number of patients did not consider that all staff showed them respect.

## Good practice

- Crofton had piloted the use of the Broset violence checklist (BVC). This pilot resulted in a 37% decrease in patient incidents. Following the pilot all forensic admission wards began using the BVC.
- A smoking cessation clinic operated seven days per week. The fresh air project operated on Friday evenings, and patients' carbon monoxide readings were taken. This was followed by a smoking cessation education session and a meal. In seven months, 63% of patients had lower carbon monoxide readings. This meant that these patients were healthier.
- Occupational therapy staff worked every day of the week and activities took place every day, including bank holidays. There were a wide variety of activities for patients during the day and evening.
- Patients activities included bricklaying and horticulture. When patients were discharged from hospital they could return for these activities to gain national vocational qualifications.
- The same consultant psychiatrists and psychologists worked on Heath and Joydens. Female patients transferring from medium security to low security had the same psychiatrist and psychologist. This was particularly important for women who had a poor experience of relationships with others.
- Real work opportunities were available, and patients worked for external organisations. This meant that they could get work references increasing their chances of future employment.
- A carers telephone line operated week days to provide support for carers.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that all patients' care plans are detailed, and reflect all of the patients' needs.
- The provider should review blanket restrictions and practices and whether they are justified by the characteristics of the patient group on each ward.
- The provider should review and ensure that patients can make telephone calls on wards in privacy.
- The provider should ensure that patient confidentiality and dignity is maintained and that patients are not required to queue to receive their medicines.

## Oxleas NHS Foundation Trust

# Forensic inpatient/secure wards

## Detailed findings

### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Danson Heath Joydens Crofton Birchwood Burgess	The Bracton Centre
Greenwood Hazelwood	Greenwood and Hazelwood

### 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.

- During the April 2016 inspection, we found that patients on Hazelwood did not always have a copy of their section 17 leave forms. At the current inspection, we found that patients were provided with a copy of their section 17 leave forms.
- At the April 2016 inspection, we found that staff had not received training on the MHA code of practice. At the current inspection, 83% of staff had training in the MHA and MHA Code of Practice. Overall, staff had a good understanding of the MHA Code of Practice.
- During the April 2016 inspection, we found that patients did not always have detailed capacity assessments concerning the patients' consent to treatment. At the current inspection, patients' capacity to consent to treatment was recorded in detail.
- During the April 2016 inspection, we found that patients were not routinely reminded of their rights under the

# Detailed findings

MHA. At the current inspection, overall, patients were regularly informed of their rights under the MHA. However, on Joydens, some patients were not reminded of their rights at regular intervals or at significant points.

- The wards displayed information regarding the MHA, including information concerning the independent mental health advocate (IMHA). An IMHA visited the wards weekly to meet with patients and attend patient meetings.

- Two psychologists were Responsible Clinicians. This meant the professionals in charge of some patients' treatment were psychologists rather than psychiatrists. Patients' treatment was led by the most appropriate professional.

## Mental Capacity Act and Deprivation of Liberty Safeguards

All of the staff working in the forensic service had undertaken Mental Capacity Act (MCA) training.

Staff understood the principles of the MCA, and supported patients to make decisions. Staff were aware that if a patient made an unwise decision this may not indicate a lack of capacity. Capacity assessments were undertaken by medical staff, with the assistance of psychology staff.

There were no patients detained under the Deprivation of Liberty safeguards.



# 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

- There was a secure entrance to the Bracton Centre, including an air lock and search room. A fixed metal detector had been ordered and was awaiting delivery. Greenwood and Hazelwood each had separate secure entrances. Entry and exit for patients was controlled by staff.
- Nursing staff were able to directly observe most of the ward areas. On Burgess, Crofton and Heath, parabolic mirrors had been installed so staff could also view 'blind spots'. Convex mirrors had also been installed on Greenwood and Hazelwood and more mirrors were due to be installed. Where mirrors had not been installed, staff managed these areas by observation.
- Some of the wards had anti-ligature fittings such as taps and door handles. Other wards, such as Joydens, Greenwood and Hazelwood had plans to replace some fixtures and fittings with anti-ligature ones. However, there was no date when this work would be completed. In the meantime, these risks were managed by staff observation, with clear procedures in place.
- At the inspection in April 2016, we found that ligature risk assessments for the wards did not include ligature risks in communal areas. During this inspection, the ligature risk assessments identified the ligatures in all rooms and communal areas. Ligature risk assessments included photographs of ligature points. Staff knew the ligature points on the wards where they worked. Staff observed these areas to minimise risks. Ligature cutters were available and staff knew where they were kept.
- During the April 2016 inspection, we found plastic bags on the wards, in ward bins and laundry rooms. During this inspection, there were no bags on the wards. However, two weeks before the inspection, a staff member had mistakenly given a plastic bag to a patient on Joydens. This led to an incident.
- Every ward, except Birchwood, had a clinic room. Electronic blood pressure machines and weighing scales were in each clinic room. Clinic rooms also contained oxygen and resuscitation equipment. The resuscitation equipment was checked and maintained regularly. Each clinic room had clinical waste bags and sharps bins which were not over-filled. The clinic rooms were clean and orderly. However, the clinic room on Greenwood was cluttered.
- A sign was posted on the bedroom door of each patient. This indicated whether or not the patient required assistance to evacuate in the event of a fire.
- During the April 2016 inspection, we found that the seclusion rooms did not meet Mental Health Act Code of Practice standards. This related primarily to the seclusion room on Heath. During the current inspection, the Heath seclusion room was in the process of being rebuilt and was not in use. The Hazelwood seclusion room had been decommissioned and was no longer used. The seclusion room on Burgess had also been decommissioned. However, it was in use at the time of the inspection, due to building work on Heath. We were not able to observe this seclusion room during the inspection.
- All of the wards were clean and had good lighting. Corridors were clear and clutter free. Furniture was sturdy and in good condition.
- In 2016, wards on both hospital sites had patient-led assessments of the care environment (PLACE). At the Bracton Centre, cleanliness was rated at 96% and at Memorial Hospital was 98%. The trust and national average were 98%. The wards' condition, maintenance and appearance at Bracton Centre was 99%. At Memorial Hospital wards the rating was 98%. These were above the trust average (97%) and the national average (93%). Urgent maintenance repairs were carried out promptly.
- Infection control audits were undertaken on each ward. All staff undertook infection control training. Handwashing signs were in place above sinks. Alcohol hand gel was also available for staff.

### Safe staffing

- During our inspection in April 2016, two nursing staff worked each shift on Birchwood, the pre-discharge

# Are services safe?

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

ward. One staff member would be left on the ward alone when the other staff member was facilitating patient leave. This was unsafe. During the current inspection, three nursing staff worked on day shifts on Birchwood. This meant there were always at least two staff on the ward. At night, two staff worked on the ward. Neither of these staff had to respond to emergency alarms off the ward.

- A staffing review had taken place, involving benchmarking staffing levels with other forensic services. This had led to an increase in nursing staff on wards. On Burgess, Crofton, Heath and Joydens staffing levels were increased from four staff on day shifts to five staff. Night staffing levels increased from three staff to four. The night staffing levels had also been increased on Greenwood and Hazelwood. These additional nursing posts had created staff vacancies and the trust were recruiting nursing staff.
- The number of registered nurse posts for the wards was 102, and 20% (20) of these posts were vacant. Six wards had a vacancy rate of 20% or more for nurses. The highest vacancy rates were on Birchwood (29%) and Crofton (23%). Ten nurses were awaiting completion of pre-employment checks before starting work in the service.
- The number of support workers on the wards was 106, and 17% (16) of posts were vacant. Three wards had vacancy rates of 20% or higher for support workers. The highest vacancy rates were on Birchwood (32%) and Joydens (24%).
- In the previous 12 months the staff sickness rate was 5%. The highest levels of staff sickness were on Burgess (12%), Heath (8%) and Danson (7%). The turnover rate of staff in the previous 12 months was 15%. The highest turnover of staff were on Joydens (26%), Birchwood (24%) and Crofton (19%).
- In the previous three months there had been 4,605 shifts on the wards requiring bank or agency staff. Sixty eight per cent (3,149) of these shifts were for support workers. Overall, 94% of shifts for nurses and support workers were filled.
- Sixty (6%) nurse shifts were not filled and most of these shifts were on Crofton, Heath and Joydens. On Joydens, 15% of nurse shifts were not filled. Five per cent (161) of support worker shifts were not filled. The number of

unfilled shifts was higher on Heath (52 shifts) and Crofton (50 shifts). In the six months before the inspection, short staffing led to the completion of 30 incident reports. These were highest on Joydens (9), Heath (6) and Hazelwood (6).

- When bank staff were required, these were mainly permanent staff working additional shifts. On occasions, additional staff were also needed and the service used agency staff. However, this was not common.
- The managers of each ward were able to adjust staffing levels. Staffing levels were increased for a range of reasons. Continuous observation of patients, patient escorts and seclusion or long term segregation all led to increased staffing numbers.
- There were enough staff for patients to have regular one to one time with their primary nurse. Information from the trust indicated that patients' section 17 leave had been cancelled once in the previous 12 months due to staffing levels. Some patients reported that section 17 leave was rearranged at times due to a shortage of staff. Activities were not cancelled due to shortages of staff.
- There were enough nursing staff on both hospital sites to respond to emergencies on the wards. This included where staff had to use physical restraint to manage patient risks.
- Outside of normal working hours, a junior doctor was on-call. The junior doctor was not based at either of the hospital sites. However, they could attend each of the sites quickly if required. A consultant forensic psychiatrist was also on-call outside of working hours. They were available to provide advice and to attend a ward if required. Senior forensic nursing staff were also on-call outside of normal working hours.
- Ward staff were required to undertake 19 types of mandatory training. The overall mandatory training completion rate for ward staff was 93%. The mandatory training rate for other staff, including doctors, was 90% overall.

## Assessing and managing risk to patients and staff

- In the six months before the inspection, there had been 25 incidents of seclusion. These were highest on Heath (11), Crofton (5) and Greenwood (5). During the same time, there were four episodes of long-term segregation.

# Are services safe?

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

- In the six months before the inspection, there were 67 incidents of patient restraint. Over a third of all restraints (27) were on Heath. On Joydens there were 12 restraints and on Crofton there were nine. The number of restraints across the service fluctuated from three in a month to 19. In total, eight patient restraints were in the prone position. There were two each on Heath, Joydens and Crofton. Staff knew that restraining patients in the prone position should be avoided wherever possible. Staff knew that if prone restraint was necessary, the patient should be in the prone position for the shortest time possible.
- Patients had a risk assessment before admission to the service. The multi-disciplinary team (MDT) also had a pre-admission meeting. The purpose of this meeting was to discuss the patient and arrange how they would be admitted to the ward. The number and types of staff required were discussed.
- We reviewed 23 patients' clinical records. All of the patients in the service had a HCR-20 (historical, clinical, risk management) risk assessment completed following admission. The HCR-20 is a structured risk assessment for violence commonly used in forensic services. Patients' HCR-20 risk assessments were comprehensive and detailed. HCR-20 risk assessments were updated every three or six months.
- Crofton had piloted the use of the Broset violence checklist (BVC). This is an easily used and understood way of assessing patients' increasing level of aggression. The BVC for each patient was discussed several times a day. If the BVC indicated there was an increased risk of aggression, staff could intervene early to prevent violence. The pilot of the BVC on Crofton resulted in a 37% decrease in patient incidents. Following the pilot all forensic admission wards began using the BVC. Best practice guidance recommends the use of tools such as the BVC (Violence and aggression: short-term management in mental health, health and community settings, National Institute of Health and Care Excellence [NICE], 2015). Other forensic wards were implementing a care zoning tool, reflecting decreased risk of patients on these wards.
- Staff used the BVC and their knowledge of patients to intervene when the risk of violence was increased. Staff then used de-escalation skills to reduce the risk of violence. Staff physically restrained patients only when de-escalation had been unsuccessful.
- Crofton had also started piloting safewards. This is a recognised way of working which reduces incidents of conflict, violence and aggression.
- A number of blanket restrictions and practices were in place following a serious incident in 2016. On each ward, two patients' bedrooms were searched each week. All of the wards had plastic cutlery and all patients were searched on return from leave. Patients could not use mobile phones on the wards. These restrictions applied to different types of wards and patient groups. For instance the restrictions on medium secure admission wards were the same as the low secure, rehabilitation and pre-discharge wards. This meant that restrictions and practices were not based on individual patient needs or risk assessments. However, a restrictive practices reduction meeting took place, which patients also attended. This meeting aimed to identify how restrictive practices could be minimised.
- A security review undertaken by professionals from outside of the trust was due to take place. The senior management team welcomed this review. A nurse had responsibility for security. However, they undertook this role for two days per week. The service was recruiting a full time security manager. Three security staff were also being recruited to undertake patient and visitor searches at the Bracton Centre reception. This meant staff would not have to leave the wards to conduct these searches.
- The service had policies and procedures for searching patients and visitors and for the observation of patients. The service also had a visitors policy.
- Seclusion of patients was used only when necessary. At Memorial Hospital, the seclusion room for Greenwood and Hazelwood had been decommissioned.
- Seclusion records were complete, and recorded the patient's behaviour whilst in seclusion. Seclusion reviews took place as recommended. However, on one of the Mental Health Act visits, staff did not complete the appropriate records for a patient on Kelsey. The patient was the only patient on Kelsey and had been segregated

# Are services safe?

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

from other patients. Staff were unaware that this constituted long term segregation. During this inspection, there were records recording that the patient was in long term segregation.

- All staff had undertaken safeguarding children training and 97% of staff had undertaken safeguarding adults training. Staff understood how patients could be vulnerable and took action to protect them from harm. For instance, during a multi-disciplinary team (MDT) meeting, the possibility of individual patients being vulnerable to exploitation or violence was discussed. Staff took action to minimise these potential risks. Staff had a good understanding of safeguarding adults and safeguarding children.
- All medicines used were within their expiry dates and were stored appropriately. The temperature of medicines refrigerators was checked regularly. Patients' medicine administration records were legible and properly completed. Any allergies patients had were recorded on the medicine administration records. A pharmacist or pharmacy technician visited each ward weekly.

## Track record on safety

- There had been one serious incident in forensic services in the previous 12 months.
- Immediately after this incident, a number of changes were made to ensure the safety of patients and staff. An investigation into the incident had taken place and an action plan had been produced. Almost all parts of the action plan had been completed by the time of the current inspection. The senior management team also welcomed an independent security review, which was due to take place shortly after the inspection.

## Reporting incidents and learning from when things go wrong

- In the six months before the inspection, 751 incidents were reported by staff. The number of incidents reported indicated a staff culture of reporting incidents. A range of incidents were reported on all wards. Types of incidents reported included infection control, medicine errors, security incidents, accidents, violence and aggression and self harm. Staff knew how to report incidents and what incidents should be reported.
- Incidents in the service were discussed twice weekly amongst the management team at the 'Bracton briefing' meeting. This meeting enabled learning from incidents to take place across the service. For example, a patient had been mistakenly handed a plastic bag, and this led to an incident. All staff in the forensic services were then reminded that plastic bags were banned items for patients. Managers also reviewed incidents with staff in team business meetings and e-mailed staff regarding incidents in the service. Staff discussed incidents in MDT and nursing handovers. The trust sent information to staff about serious incidents that had occurred in other services by email. The Bracton briefing was sent to all staff in the forensic service every week. The briefing informed staff about any incidents that had occurred in the previous week.
- Staff and patients were offered de-briefing meetings following incidents.

## Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Managers and senior staff knew about the duty of candour. They were aware that an apology should be made when mistakes were made and were open and transparent when this happened.

# 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

- Prior to admission, all patients were assessed by a consultant psychiatrist and a senior nurse. This assessment included the patient's physical and mental health, and risk behaviours.
- Following admission, all patients were assessed within 24 hours by a consultant psychiatrist. All patients had a comprehensive physical health assessment, including blood tests. Patients also had assessments with the occupational therapist, psychologist and nursing staff. All patients had an IQ test.
- Patients' immediate needs were recorded in an initial care plan for the patient. These care plans were then developed over the first week of the patients' admission.
- Patients' care plans varied in quality across the forensic services. Care plans on Heath were comprehensive and detailed. On Joydens, patients' care plans addressed all of the patients' needs but were brief, and not detailed. On Greenwood and Hazelwood, some care plans lacked detail and did not always address patients' needs. For example, one patient's care plans did not address their physical health, continence and memory problems. Plans were in place to transfer this patient to a more suitable service. Some patients' daily nursing notes referred to care plans which did not exist.
- Patients had care programme approach (CPA) meetings, to review their care and treatment, and plan for the future. Patients, their families and relevant professionals were invited to these meetings.
- During the inspection in April 2016, following changes in the use and purpose of Joydens and Heath, some female patients were waiting to be assessed to determine which levels of security would best meet their needs. At this inspection, all female patients had been assessed and were on the appropriate wards.

### Best practice in treatment and care

- When patients were prescribed medicines, doctors considered best practice guidance from the National

Institute of Clinical Excellence (NICE). Patients were prescribed medicines in accordance with a range of NICE guidance. Patients 'as required' (PRN) medicines were reviewed regularly.

- A range of psychological treatment was available for patients in the forensic services. These included cognitive behaviour therapy, dialectical behaviour therapy, schema focussed therapy and mentalisation-based therapy. Groups for patients had a focus on offending behaviour and reasoning and rehabilitation. One of these groups was called 'Know your own risks.' The group helped develop patients' understanding of how staff viewed risk and involved an explanation of the HCR-20 risk assessment document. After the group staff worked with patients to complete their own risk assessment on an individual basis. The psychological therapies for patients were those recommended by NICE.
- Psychologists and occupational therapists provided specific advice regarding the care of patients with mild learning disabilities. For example, a psychologist had prepared a social story involving words and pictures to help a patient with autism prepare for discharge from hospital. Social stories are ways to help people with autism develop greater social understanding.
- A general practitioner, dentist, optician and physiotherapist visited the hospital sites regularly. Patients had electrocardiograms (ECGs) before being prescribed antipsychotic medicines, and had ongoing physical health monitoring. Staff used the modified early warning score (MEWS) to monitor patients physical health. Staff monitored patients' food and fluid intake using food and fluid charts where required.
- In addition to a dedicated physical health nurse, the service had created a forensic integrated care worker post. This role included supporting patients to address their physical health needs and facilitating the wellbeing group. The forensic integrated care worker also supported visiting professionals, including the dietitian.
- The forensic services were smoke-free. A smoking cessation clinic operated seven days per week. The fresh air project on Friday evenings and patients' carbon monoxide readings were taken. This was followed by a smoking cessation education session and a meal. In

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seven months, 63% of patients had lower carbon monoxide readings. This meant patients were healthier. A range of nicotine replacement therapy was available to assist patients to stop smoking.

- Staff measured patients' progress in treatment using the clinical outcomes in routine evaluation (CORE-10). The CORE-10 was undertaken for patients every three months. The service also used the health of the nation outcome scales (HoNOS – secure) to measure client outcomes. Locus of control monitoring took place every three months, which indicated patients' risk of re-offending.
- Staff completed a number of clinical audits in the service. In the previous year, the service had undertaken a survey of patients' physical health problems, and the patients' understanding of their problems. This had led to specific interventions to assist the patient with their physical health needs. An audit of patient care plans had taken place, and the results were being collated at the time of the inspection. Other audits took place regarding infection control, psychological outcomes, and the use of the Broset checklist.

## Skilled staff to deliver care

- Ward teams consisted of medical staff, nurses, psychologists, occupational therapists and social workers. The male medium secure admission wards each had a dedicated psychologist, psychology assistant, occupational therapist and therapeutic working day staff.
- Staff working in the service were experienced and qualified to provide care and treatment. All staff had regular supervision and an annual appraisal.
- Staff were supported to undertake a range of additional training and education, including diplomas and master's degrees. Nursing staff were provided with training on substance misuse. Staff on the female wards had received training regarding people with personality disorders and training concerning birth control. A staff member had learnt British sign language to be able to communicate with a patient. However, at Memorial Hospital, staff had not received training regarding dementia. This meant they did not have the knowledge or skills to support one of the patients effectively.

## Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary team (MDT) meetings on the wards, including ward rounds and MDT handover meetings. The MDT handovers were detailed and every patient was discussed amongst the MDT. Members of the MDT showed mutual respect for each other and worked collaboratively to meet the needs of patients. Nursing handovers included all relevant information regarding patients, including the patients' Broset score.
- Staff in the service maintained effective relationships with other services and organisations. There were strong links with learning disability services, who provided assessments and support for patients with suspected learning disabilities. The service also maintained effective links with patients' community mental health teams and organisations which could assist patients with work experience.

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

- Mental Health Act (MHA) reviewers undertook visits on Heath, Joydens and Burgess immediately prior to this inspection.
- A MHA administrator was based at Bracton Centre and managed the paperwork regarding patients' detention, renewal of detention and appeals. Staff knew how to contact the MHA administrator for advice, when needed.
- The wards displayed information regarding the MHA, including information concerning the independent mental health advocate (IMHA). An IMHA visited the wards weekly to meet with patients and attend patient meetings.
- During the April 2016 inspection, we found that patients on Hazelwood did not always have a copy of their section 17 leave forms. During this inspection, we found that patients were provided with a copy of their section 17 leave forms. Patients' section 17 leave forms clearly recorded the length and type of leave each patient had. Older section 17 leave forms were struck through indicating they were no longer valid. Where patients required Ministry of Justice authorisation for leave, this authorisation was included with their section 17 records.

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- Two psychologists were Responsible Clinicians. This meant the professionals in charge of some patients' treatment were psychologists rather than psychiatrists. Patients' treatment was led by the most appropriate professional.
- At the April 2016 inspection, we found that staff had not received training on the MHA Code of Practice. During this inspection, 83% of staff had training in the MHA and MHA Code of Practice. On four wards less than 85% of staff had such training. They were Heath (50%), Joydens (70%), Greenwood (80%) and Danson (83%).
- During the April 2016 inspection, we found that patients did not always have detailed capacity assessments concerning the patients' consent to treatment. During this inspection, patients' capacity to consent to treatment was recorded in detail. The capacity assessments provided details of how patients' capacity had been assessed. Staff attached consent (T2) or authorisation (T3) certificates concerning the patients' treatment to their medicine charts.
- During the April 2016 inspection, we found that patients were not routinely reminded of their rights under the

MHA. At this inspection, overall, patients were regularly informed of their rights under the MHA. On Greenwood and Hazelwood, patients were informed of their rights every three months. An audit was conducted on Greenwood ward to ensure this took place. However, on Joydens, some patients were not reminded of their rights at regular intervals or at significant points. Significant points include following tribunals and when detention is renewed.

## Good practice in applying the Mental Capacity Act

- All of the staff working in the forensic service had undertaken Mental Capacity Act (MCA) training.
- Staff understood the principles of the MCA, and supported patients to make decisions. Staff were aware that if a patient made an unwise decision this may not indicate a lack of capacity. Capacity assessments were undertaken by medical staff, with the assistance of psychology staff.
- There were no patients detained under the Deprivation of Liberty safeguards.

# 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

- Staff spoke with patients in a respectful and caring manner. Staff spoke enthusiastically about patients and demonstrated a sensitive, caring approach towards patients. Staff intervened if they thought patients were becoming distressed.
- When patients displayed behaviour which challenged staff, the staff team had 'positive slant' meetings. These meetings were based on an adaptive behaviour model and reviewed the reasons why a patient may behave the way they do. The 'positive slant' meetings assisted staff to maintain a positive and empathic outlook when caring for these patients.
- Most patients were positive regarding staff. They said that staff treated them with kindness and respect and were genuinely interested in their care and wellbeing. Patients reported that staff were fair and caring. Some patients gave praise to particular staff members. However, a small number of patients did not consider that all staff showed them respect. The 2016 annual survey of patients found that 95% of patients considered they were treated with respect.
- Staff demonstrated a good understanding of patients' needs. During MDT handovers and nursing handovers, staff spoke with real insight into patient's needs and preferences.
- The 2016 PLACE scores for privacy, dignity and wellbeing were 99% at the Bracton Centre and 95% at Greenwood and Hazelwood. The trust average was 92%, and the national average was 84%.
- On Joydens, patients queued up at the clinic room to receive their medicines. Patients told us they were unhappy with this. This was not in accordance with best practice.
- Staff knocked on patients bedroom doors before entering. Patients' bedroom doors had visors on the window which could be operated by the patient. This meant patients could maintain privacy and dignity and could prevent people seeing into the bedroom. However, on Joydens patients' bedroom doors did not

have visors. Bedroom doors had a curtain placed outside of the bedroom window, which could be opened by staff or patients. There was a plan to replace the bedroom windows on Joydens with visors.

- On Greenwood, one patient's bedroom was not en-suite. The toilets on the ward were kept locked in order to mitigate risks. This meant the patient had to ask staff each time they wanted to use the facilities. This did not promote the patient's dignity.

### The involvement of people in the care that they receive

- When patients were admitted to the service staff gave them a comprehensive information booklet. This booklet contained a variety of information including different staff roles, meal times and how patients could complain.
- Almost all patients had a copy of their care plan and this was recorded in their clinical records. Some patients had provided significant input into their care plan. Other patients had more limited involvement in the development of their care plans. Two patients did not know if they had care plans.
- Posters on the wards contained details of the patient advocacy service. Patient advocates visited all of the wards on a regular basis.
- Patients were supported to maintain contact with their families. One patient had internet video sessions arranged as their family lived abroad. Family members and carers were invited to attend patient's CPA meetings.
- A consultant psychiatrist on Hazelwood met with carers each week. At the Bracton Centre, there was a monthly carers meeting. At the Bracton Centre there were also summer and Christmas fairs for carers, and an annual awards ceremony. A carers' telephone line operated week days to provide support for carers.
- In August 2016, patients were asked to complete an annual survey conducted by the trust. Sixty one per cent of patients completed the survey. The service also conducted ongoing surveys to gain patients' views on five questions about their treatment. In March 2017, 14 patients from six wards responded. Thirteen of the 14 patients responded that they had been involved in decisions about their treatment. All of the patients



## Are services caring?

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reported they had been provided with enough information about their care and treatment. Patients were also able to provide feedback immediately after their CPA by using an electronic feedback system.

- Patients chaired weekly ward community meetings. These meetings were a forum for patients to provide

feedback. For instance, patients on Heath fed back that there were too many professionals in their ward rounds. Following this, fewer professionals attended the ward rounds.

- Patients were involved in decision making regarding the service. Patients attended the social events committee and were involved in decision making. Patients also attended the reducing restrictive practices meeting. Patients operated the Bracton against drugs group.

# Are services responsive to people's needs?

Outstanding 

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

## Our findings

### Access and discharge

- In the previous six months, the average waiting time from a patient being assessed until admission to a ward was 33 days. The shortest time was 4 days, and one patient waited 148 days until admission to a ward.
- Overall average bed occupancy in the previous six months was 94%. All of the wards had bed occupancy of more than 85%. In the previous six months, 15 patients had their discharge or transfer of care delayed. This was an average of 4.5% of patients. The highest number of delayed discharges or transfers of care were on Joydens (11%), Birchwood (10%) and Hazelwood (9%). The main reason for the delays was due to difficulties in finding suitable community accommodation for patients.
- The number of out of area placements attributed to this core service in the last six months was three.
- There were two flats for patients on Joydens, so that female patients could live more independently before being discharged. Birchwood included 'the farmhouse' in the hospital grounds. This was for male patients to live more independently before discharge. The forensic service had been instrumental in developing a community hostel for patients to go to when discharged.

### The facilities promote recovery, comfort, dignity and confidentiality

- The service had a full range of rooms and equipment for patients' care and therapy. There were quiet areas and group rooms on each ward.
- The patients' telephone on each ward had a hood to provide privacy. However, the phone hoods did not provide this, and patients reported that their phone calls were not private. On some wards, patients could use the cordless staff telephone to speak with their solicitor.
- Each of the wards had an outside area for patients. At the Bracton Centre, patients could also have ground leave within the secure perimeter. They could use a large outside area, which included an outside gym.

- In 2016, the PLACE score for food at Greenwood and Hazelwood was 96%. This was above the national average (89%) and the trust average (94%). The quality of the food at the Bracton Centre had not been assessed during the 2016 PLACE visit.
- Patients on low secure wards and Birchwood, the pre-discharge ward, cooked for themselves. On the medium secure wards, patients had food, which had been cooked, then chilled and reheated. Patients on the medium secure wards did not like the cook chilled food. Some patients considered the portion sizes were too small. The management team were aware of patients' views regarding the food. Plans were being developed to build a kitchen at the Bracton Centre, which would have a chef.
- Patients were able to access the internet, and there was an internet café at the Bracton Centre.
- Drinks and snacks were available for patients throughout the day and night.
- Most patients had keys to their bedrooms so they could safely store their property. Keys were provided to patients following a risk assessment.
- Patients had individual jobs on the wards such as chairing community meetings, and basic cleaning tasks.
- Occupational therapy staff worked every day of the week and activities took place every day, including bank holidays. There was an exceptional range of individual and group activities during the day and evening. Activities included cycling, design and technology, a rock choir and picture framing. Artwork produced by patients was displayed in art galleries and had been commissioned by another health provider. Patients gained recognised qualifications through adult education groups in literacy and numeracy. Patients activities included bricklaying and horticulture. When patients were discharged from hospital they could return for these activities to gain national vocational qualifications. The activity programme was focussed on patients' strengths and interests and provided patients with a range of choices.
- The service was starting a forensic recovery college shortly after the inspection. Four courses were planned, three operating for eight weeks and the other for six weeks. There were planned separate male and female

# Are services responsive to people's needs?

Outstanding



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

- courses covering self-care, relationships and wellbeing. Other courses explored mental health diagnoses and life after discharge from hospital. The recovery college aimed to recruit patients as assistant facilitators to deliver courses.
- Real work opportunities were available, and patients worked for external organisations. This meant that they got work references increasing their chances of future employment. The trust had set up a social enterprise. Patients prepared food to sell, and the income from this was used to pay patients and for the hospital charity. At Greenwood and Hazelwood, patients operated a seasonal car washing service on the hospital site.
- Two gym instructors worked at the Bracton Centre and the gym was open five days a week. There was also an outside gym in the grounds. Groups included football and boxing, and male and female sports groups. The judo group involved patients and staff learning judo. The two police liaison officers for the service also attended this group. Patients at Greenwood and Hazelwood also had access to a gym.
- The same consultant psychiatrists and psychologists worked on Heath and Joydens. Female patients transferring from medium security to low security had the same psychiatrist and psychologist. This was particularly important for women who had a poor experience of relationships with others. By having the same psychiatrist and psychologist the patients had continuity of care.
- At both hospital sites, the service was accessible for all people, including wheelchair users. Some rooms were designed to be wheelchair accessible.
- Information leaflets were available in a range of languages, and easy read versions were also available. Interpreters were available for patients, including non-English speakers and users of sign language. Staff knew how to book interpreters.
- Different types of food were available for patients to cater for their religious, cultural or health needs.
- The Bracton Centre had a multi-faith room. Shower rooms were also available for ablutions. A number of faith leaders visited each of the hospital sites to see patients. Patients were escorted by staff to attend places of worship. On Sundays, a group operated for patients to reflect on spiritual care.

## Listening to and learning from concerns and complaints

- In the 12 months before the inspection there had been 16 complaints. Nine complaints were upheld or partially upheld, and five were not upheld. Two complaints were being investigated at the time of inspection. Complaints were thoroughly investigated.
- Information on how to make a complaint was displayed throughout the service. Patients knew how to make a complaint. Almost all patients considered that a complaint would be taken seriously.
- Complaints were monitored and reviewed on a regular basis. Staff learnt from complaints through their ward team meetings.

## Meeting the needs of all people who use the service

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- Staff knew and understood the trust vision and values. Staff demonstrated the vision and values in the way they worked with patients.
- Staff knew who the senior managers in the trust were. Staff reported that the trust senior management team and board members visited the wards.

### Good governance

- During the April 2016 inspection, we found that risks within the service had not been addressed effectively. This specifically related to ligature risks. At the current inspection, the trust had responded to a range of risks, which had been highlighted in the previous year. Ligature risks were being addressed, and priority had been given to wards where there were increased risks. On wards where ligature risks had not yet been removed or minimised, these risks were managed with clear procedures in place.
- At the April 2016 inspection, we found that audits did not translate into action at ward level. At the April 2017 inspection we found that audits were acted upon. For instance, an audit of the effect of the Broset violence checklist led to it being used on other wards.
- There had been an increase in the number of nursing staff on the ward. Staffing levels were similar to other forensic services. A rotational scheme for band 5 nurses to gain different forensic experience had been successful.
- There were high rates of completion of staff mandatory training, and staff received regular supervision and appraisal.
- Complaints, incidents and patient feedback were used to improve the safety and quality of the service. The patient safety, clinical improvement and patient experience groups were used to share learning across the wards and to improve the service. A monthly security forum reviewed security incidents in the service, so that learning could take place.

### Leadership, morale and staff engagement

- During the April 2016 inspection, we found that the leadership team had failed to act promptly when ward managers highlighted risks. There was a lack of urgency regarding improvements and changes took a long time to implement. At the current inspection, we found that a number of improvements had been made. The senior management team were focussed on risks in the service, and improvements were being made in a timely manner. A number of safety improvements had taken place and were continuing.
- A new service director was in post and had plans to strengthen the leadership and management of the service. The service director also intended to focus more closely on staff engagement. The service director made unannounced visits to the wards to engage with staff. The senior management team were aware of areas for improvement and were committed to improving care and treatment for patients.
- Clinical team leaders and consultant psychiatrists provided strong ward leadership, particularly on Burgess, Crofton and Greenwood. Patients specifically praised individual senior staff on Burgess and Crofton.
- Staff felt supported by their immediate managers. There were no cases of bullying and harassment and staff morale was good. Staff were confident to use the whistleblowing procedure and to raise concerns. There was a strong sense of team working and mutual support.
- There were opportunities for staff to develop, and continuous learning was supported by the management team.

### Commitment to quality improvement and innovation

- The service took part in self and peer reviews with the Royal College of Psychiatrist's quality network for forensic mental health services.
- The service was working with two other mental health trusts as part of the South London Forensic Partnership. This new way of working meant that the three trusts would commission and pool forensic resources to benefit patients. The South London Forensic Partnership was the only pilot for this way of working in England.