The North London Clinic

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The North London Clinic as requires improvement because:

- The senior leadership team of the hospital had been unstable since the hospital's merger with another provider in December 2016, which meant there had been inconsistent leadership. Although there was a governance framework in place, new systems and processes had not yet been fully embedded since the merger, and staff could not always find key information to help them deliver their role effectively.
- There had been a high turnover of ward managers, which meant there was a lack of leadership and experience at ward level. Most deputy ward manager posts were vacant, which meant ward managers did not always have sufficient leadership support on the wards. Staff morale was low.
- There was a high vacancy and turnover rate for the nursing teams across the hospital. This had led to an over reliance on bank and agency staff.
- Physical healthcare monitoring was not being carried out consistently to meet the individual needs of patients. There was no effective oversight of physical health monitoring systems within the hospital.
- The hospital did not have enough personal alarms for all staff and external visitors, and they were not all in working order.
- The hospital did not ensure there were effective systems in place for all staff to hear about and learn from incidents and complaints. Team meeting minutes did not demonstrate that they happened every month as managers said they should. Care record audits were not being carried out.
- Patients who were detained had limited access to an Independent Mental Health Advocate.
- The wards did not always promote patient recovery. The wards were not well maintained and did not provide a therapeutic environment. The hospital did not ensure staff engaged with patients following a seclusion episode, which meant patients were not provided with a de-brief and offered any additional support they may have required.
- Carer needs were not always being met. Carers reported that communication could be improved between carers and staff at the hospital.

We found these areas of good practice:

- There was a proactive approach to anticipating and managing individual risks for patients. Up-to-date risk assessments and management plans were in place for all patients. There were systems in place for safeguarding patients.
- Patients' needs were fully assessed. Care plans were comprehensive, holistic and person centred. Patients co-produced their care and risk management plans. The hospital provided a range of psychological therapies and interventions recognised by guidance from the National Institute for Health and Care Excellence.
- The hospital was good at involving patients in their care and treatment. There were opportunities for patients to feedback on the services they received at the hospital.
- Patients were supported with their recovery journey. There was an extensive programme of individual and group activities that reflected patients' individual needs and preferences.
- The hospital's risk register matched staff concerns and our concerns found during the inspection. Detailed plans were in place to make improvements and senior management discussed the risk register regularly. Leaders had recognised the recent hospital merger had been a challenging time for staff, and had been proactive in engaging with staff and working to improve morale.

Summary of findings

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Forensic inpatient/secure wards.

Summary of this inspection

Background to The North London Clinic

The North London Clinic is a 60-bed all-male specialist unit, which provides a full care pathway from medium to low secure, and to a locked rehabilitation wing. The hospital provides treatment to men who have a diagnosis of mental health disorder and associated challenging behaviour.

The provider of North London Clinic, Partnerships in Care, recently merged with the Priory Group in December 2016.

Services are provided on the following wards:

- Coleridge Ward is an acute admission medium secure ward providing care and treatment for up to 16 male adult patients.
- Keats Ward is a treatment medium secure ward providing care and treatment for up to 15 male adult patients.
- Byron Ward is a low secure ward providing care and treatment for up to 10 male adult patients.
- Tennyson House is a low secure rehabilitation ward providing care and treatment for up to 19 male adult patients.

The service was last inspected in April 2015 and received an overall rating of outstanding, with a rating of outstanding in effective and well-led, and a rating of good in safe, caring and responsive.

The service had a registered manager employed at the hospital at the time of inspection.

The provider is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Our inspection team

The team comprised: four CQC inspectors, one CQC inspection manager, two CQC assistant inspectors, a Mental Health Act reviewer, a student nurse, two specialist advisors with professional backgrounds in forensic nursing, and an expert by experience. Experts by experience are people who have developed expertise in health services by using them.

Why we carried out this inspection

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

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 the hospital.

During the inspection visit, the inspection team:

Summary of this inspection

- visited all four wards of the hospital, looked at the quality of the environment and observed how staff were caring for patients
- spoke with 25 patients who were using the service
- spoke with the ward managers or acting managers on all four wards
- interviewed staff on the senior management team, including the hospital director, director of clinical services and the quality improvement lead with responsibility for these services
- spoke with 33 other staff members; including doctors, nurses, healthcare assistants, a social worker, clinical psychologists, activities co-ordinators, an administrator, the physical health lead, the complaints and safety lead, the security lead and the advocate
- observed one lunch on Byron Ward
- observed and attended a patient community meeting on Byron Ward
- observed and attended a patient's ward round on Tennyson House
- looked at 16 electronic care records
- carried out a specific check of the medication management on the wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 26 patients across the four wards. The feedback was mixed. Some patients were positive about the support they received from staff. They said they felt relaxed and safe on the wards. They said some staff were respectful and caring, and one patient said their doctor was interested in their wellbeing. Patients said they understood why they were taking their medications and felt involved in their care. Some patients said they enjoyed activities offered to them, including the gym, games and community leave. One patient said staff were brilliant and felt able to talk to staff if they had any issues.

Some patient gave negative feedback. For example, some said there were not enough nurses on shift and there were lots of agency staff on shifts, who did not always understand their specific needs. Patients said that they did not always get their set fresh air breaks due to short staffing. Some patients said the wards were not a welcoming environment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The hospital did not ensure there were effective systems in place for learning and dissemination of incidents and complaints to all staff. The hospital did not ensure staff engaged with patients following a seclusion episode. This meant patients were not provided with a de-brief and offered any additional support they may have required.
- Not all of the personal alarms were working on the first day of inspection and where staff had highlighted alarms were not working, these had been sent for repair. Staff had been reminded to escalate where alarms were not working.
- The wards were not well maintained and did not provide a therapeutic environment for patients. Wards required redecoration, some items were broken and furniture was in need of replacement. This issue was already highlighted on the hospital's risk register and an estates plan was in place to make improvements to the environment.
- There was a high vacancy rate for registered nurses and a high turnover rate for the hospital. This had led to an over reliance on bank and agency staff. Patients said agency staff did not always understand their specific needs. Three patients and one staff member said that sometimes patients did not get a fresh air break due to short staffing or agency usage.

However:

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs. Staff across the wards carried out checks to ensure equipment was clean and well-maintained and staff checked emergency drugs daily.
- There was a proactive approach to anticipating and managing individual risks for patients. Up-to-date risk assessments and management plans were in place for all patients.
- Seclusion rooms met the design requirements of the Mental Health Act Code of Practice. Staff used seclusion appropriately and conducted the appropriate nursing and medical reviews whilst a patient was in the seclusion room. The hospital participated in a restrictive interventions reduction programme and only used restraint after de-escalation had failed.

Summary of this inspection

- Good systems were in place for safeguarding patients. The hospital had a safeguarding tracker system and proactively monitored the progress of safeguarding investigations.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Physical healthcare monitoring was not being carried out consistently to meet the individual needs of patients effectively, particularly in the management of patients with diabetes. There was no effective oversight of physical health monitoring system within the hospital.
- Patients who were detained had limited access to an Independent Mental Health Advocate (IMHA). An IMHA provides an additional safeguard for patients who are subject to the Mental Health Act and helps them to understand their position including their rights and aspects of their treatment.
- Team meeting minutes did not demonstrate that they happened every month as managers said they should.
- Physical health monitoring and care record audits were not being carried out.

However:

- Patients' needs were fully assessed. Care plans were comprehensive, holistic and person centred. Patients co-produced their care and risk management plans.
- An effective multidisciplinary team, who worked in collaboration with other organisations and agencies, supported patients.
- The hospital provided a range of psychological therapies and interventions recognised by guidance from the National Institute for Health and Care Excellence.
- New staff received an induction. Staff had access to mandatory and specialist training for their roles.

Are services caring?

Good

We rated caring as good because:

- We observed most staff interactions with patients were kind, positive and responsive.
- Staff supported patients to understand their care and treatment, and most patients said they felt involved in their care.

Summary of this inspection

- The hospital was good at involving patients in their care and treatment. Patients chaired daily morning meetings to plan their activities for the day and developed their care plans with staff. Patients worked with the occupational therapist to develop their activities timetable.
- There was a service user liaison role at the hospital. Patients in this role sat on the hospital reduce restrictive practice group.

However:

- Some carers reported that the communication with hospital staff was poor.

Are services responsive?

Good

We rated responsive as good because:

- Patients were supported with their recovery journey. There was an extensive programme of individual and group activities that reflected patients' individual needs and preferences. Patients accessed a dedicated recovery college, which supported them with their rehabilitation and discharge plans.
- Staff supported patients to maintain contact with their families and carers.
- Patients spoke positively about the choice and quality of food, which met their religious, cultural and dietary needs.
- Information on how to make a complaint was displayed throughout the service. Patients were able to give feedback on the quality of their experience and their concerns and complaints were addressed.

However:

- Ward environments were not well maintained and did not promote a therapeutic environment to support recovery.
- Staff did not receive feedback on the outcome of complaints investigations.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The senior leadership team of the hospital had been unstable since the Priory Group merger in December 2016. There had been a high turnover of senior managers, which meant there had been inconsistent leadership.
- The hospital had a governance framework in place, however, due to the recent hospital merger, the framework was still not

Summary of this inspection

yet fully embedded to ensure it was fully effective in identifying risks and areas of improvement. Staff were still getting used to the new IT systems, and did not always know how to access key information, such as complaints or ligature risk assessments.

- There had been a recent turnover of ward and deputy managers. Ward managers were inexperienced in the role or new to the organisation. Whilst the organisation was recruiting to the deputy posts at the time of the inspection, ward leadership and support was not robust
- Confidential papers were not always secured securely on the wards.
- Staff did not undertake regular and systematic audits to monitor the quality of care records and physical health support.
- Staff morale was low. Staff said this was due to low staffing levels on the wards, high turnover of staff and the recent merger with another provider. This had been highlighted on the hospital's risk register and plans were in place to improve morale.

However:

- Leaders were visible and approachable, and they attended regular staff and patient meetings.
- Leaders had recognised that the hospital merger had been a challenging time for staff, and had been proactive in engaging with them to gain their feedback and improve morale via the recent introduction of 'you say' forums.
- The hospital's risk register matched staff concerns and our concerns found during the inspection. There were detailed plans in place to make improvements. Senior management reviewed and updated the risk register in clinical governance meetings, and had developed an improvement plan to address the areas identified on the risk register.

Detailed findings from this inspection

Mental Health Act responsibilities

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

At the time of our inspection, there were 51 patients under the MHA across the four inpatient wards at the hospital. The hospital only accepted patients who were already detained, and mostly on forensic sections of the MHA. However, there were some patients subject to Section 3 of the MHA.

The hospital had recently appointed a full-time MHA administrator, following a three-month period of interim cover after the last MHA administrator left in January 2018. During the interim period, the hospital did not have a robust system in place to ensure oversight of the MHA administration.

Usually the MHA administrator ensured that all the MHA documentation was correct and sent reminders to the responsible clinicians regarding expiry dates of detentions and the completion of consent to treatment authorisations under Section 58. A record was kept of all detained patients and the timeframe for renewals, for explanation and repetition of rights, for consent to treatment certification and for referrals to and hearings by the hospital managers and the mental health tribunal. However, due to the absence of a permanent MHA administrator recently, the current spreadsheet, and consequently the paperwork in the administration office, was slightly out of date. In addition, the recent absence of the MHA administrator had led to some contradictions between what was recorded in the office and what was on the medication charts on the wards.

Patients who were detained had limited access to an Independent Mental Health Advocate (IMHA). Instead they accessed an onsite generic advocate who was not IMHA qualified. The MHA Code of Practice states that a generic advocate should not replace IMHA services, as IMHAs provide an additional safeguard for patients who are subject to the MHA and help them to understand their position including their rights and aspects of their treatment. Although the provider could make referrals to an IMHA service, they were not responsive, and as a result, the generic advocate was attending the patients' mental health tribunals and hospital managers' hearing meetings in replacement. The IMHA did not have a physical presence on the wards and there were no posters displayed on wards to inform patients on how access to the IMHA service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital provided online training in the Mental Capacity Act (MCA) 2005. The MCA applies to people aged 16 and over. Eighty-five percent of staff had been trained in the MCA.

Staff had a working knowledge of the MCA and confirmed that capacity was assumed unless proven otherwise. The provider had identified that further staff development and training was required in this area.

The service had policies and procedures in place in relation to the MCA and the Deprivation of Liberty Safeguards (DoLS). Staff could access these on the intranet.

We saw detailed records relating to the assessment and understanding of capacity across the service. Decision specific assessments had been made and the best interests of the individual considered.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Staff had good oversight of the environmental risks of the hospital. Staff completed regular risk assessments of the care environment and there were monthly health and safety meetings. The health and safety lead had recently completed a risk assessment for the whole hospital.
- It was difficult for staff on Keats and Byron Ward to observe patients at all times because of the layout of the ward, corridors and poor sightlines. Risks were mitigated by regular staff presence in these areas and the installation of convex mirrors. The hospital was also in the process of fitting CCTV to all wards as another mitigation towards the poor sightlines."
- Although the hospital completed regular blind spot and ligature point audits, ward managers were unable to access the most up-to-date audits on the IT system, and they were not displayed for staff to see in the nursing office. This meant we could not be assured that new staff coming onto to the ward could easily access the ligature points and blind spots for the ward. This was highlighted to management during the inspection who took action to ensure ligature and blind spot information were displayed on all wards.
- The blind spot audits identified the blind spots on the wards, and installed convex mirrors to mitigate them. Blind spots are areas on a ward that staff cannot easily see from a central location, like a nursing office. There was one blind spot on Coleridge Ward that did not have a convex mirror installed to minimise the risk. This had been identified on the hospital's estates plan and a blind spot mirror was due to be installed in May 2018. In the meantime, the risk was managed by staff presence. The planned addition of CCTV on the wards would support the mitigation of blind spots
- The ligature risk assessment, included ligature assessments of the bedrooms and communal areas of the ward. Where ligature points had been identified, the hospital mitigated the risk by introducing anti-ligature features (for example, collapsible curtains) and staff conducted regular patient observations. The hospital's estates plan outlined environmental work to make the environment safer. For example, on Coleridge Ward, taps were being replaced with anti-ligature taps with a completion date of May 2018. However, ward managers could not find the most up-to-date ligature and blind spot audits in a timely manner, and the audits were not displayed for staff to see in the nursing office. This meant we could not be assured that new staff coming onto to the ward could easily access the ligature points and blind spots for the ward.
- Staff had easy access to ligature cutters, which were clearly displayed in the nursing offices.
- Not all of the personal alarms were working on the first day of inspection and where staff had highlighted alarms were not working, these had been sent for repair. Staff had been reminded to escalate the issue of broken alarms
- Staff spoke of an incident of a patient assault on a staff member and the staff member's personal alarm did not go off when they called for help. Some of the inspection team's personal alarms did not work during the inspection. This issue was highlighted to management

during the inspection, and the hospital ordered ten new alarms and sent back faulty alarms. The hospital was already sighted on this issue as it was identified on the hospital's risk register and improvement plan.

- The hospital had received funding to replace doors on Coleridge and Keats Ward so that they were anti-barricade to prevent holding or blocking. At the time of the inspection, the doors had been ordered and management were making decisions based on risk as to where they would start the replacement programme.
- Reception staff managed access and exit from the hospital. They kept a log of the security keys, alarms and radios. Each ward has a designated security lead.
- The provider had systems in place to monitor the fire safety of the hospital. An external provider completed a fire risk assessment and management report in September 2017, which identified a number of actions that needed to be completed. The provider had completed all required actions by November 2017.
- The provider undertook regular tests and drills. The last drill was in November 2017 and the last fire alarm test was in April 2018. The hospital had a register of fire marshals.

Maintenance, cleanliness and infection control

- The wards were generally clean and clutter free. Cleaning records showed that the cleanliness of the wards was monitored daily.
- Although the wards were safe, they were not well maintained and did not provide a therapeutic environment for patients. A therapeutic environment refers to a physical space that promotes patient recovery. On Coleridge, Keats and Byron Wards, there were marks on the walls and paint was flaking. On Coleridge Ward, the toilet seat on the first floor was broken and carpet dividers were missing between communal rooms and the corridor. On Keats Ward, furniture was in need of replacement and a ceiling tile in the corridor had been knocked through. On Byron Ward, the clinic room and toilet door had been damaged due to a patient incident. The hospital had already identified it on their risk register and had put an estates environmental plan in place. They were sighted on most of the issues we identified during our inspection and dates had been set for environmental works to be completed. This included damaged furniture to be replaced on Keats Ward by May 2018 and ward painting on Coleridge, Keats and Byron Wards.
- An infection control audit of the hospital was carried out yearly. The next audit was due in May 2018. The hospital's practice nurse had only recently started to undertake a hand washing audit in March 2018.

Seclusion room

- The hospital had two seclusion rooms that were located on Coleridge Ward, one on each floor. Neither was in use during the inspection visit. Patients from the other wards used the seclusion rooms on Coleridge Ward if required.
- At the last inspection in April 2015, the seclusion room on the ground floor did not have a two-way communication system. This was no longer the case during this inspection. Seclusion rooms were safe and fit for purpose, as they had sight of a clock, toilet and washing facilities, safe bedding, natural light and were well ventilated. Staff were able to externally control the seclusion room's lighting and heating.
- In addition, on Coleridge Ward, there was an extra care area on the first floor that comprised of an observation area with an adjoining locked door to an open plan bedroom and a lounge area, including a seclusion room with a bathroom. Until recently, the extra care area had been used as a bedroom for patients who did not require extra care facilities. However, it had been decommissioned as a bedroom a few weeks before the inspection.
- When a patient's seclusion ended, staff did not give them a formal debrief as to why they were in seclusion or give them the opportunity to feedback on the experience. Whilst seclusion records had a section for patient de-briefs, staff had not completed it in the five records we reviewed. Staff told us there was no formal discussion for patients after seclusion. This meant that staff were not able to take away any learning regarding the seclusion episode (for example, if there was something they could have done to support the patient a bit better during the seclusion or beforehand) or identify if the patient required any extra support going forward.
- This issue was highlighted to management following the inspection. They acknowledged patient de-briefs were not formally recorded, but that de-briefs were conducted with the patient at the time of the final medical/nursing review before seclusion was ended.

Clinic room and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs. Staff across the wards carried out checks to ensure equipment was clean and well-maintained and staff checked emergency drugs daily.
- Staff maintained safe hygiene with gloves, aprons, paper towels and liquid soap that was available in clinic rooms.

Safe staffing

- The hospital's establishment level for registered nurses was 30 and the establishment level for healthcare assistants was 48.
- There were 12 vacancies for registered nurses across the hospital. This included six vacancies for Coleridge Ward, which meant there were only two permanent registered nurses on the ward. There were nine vacancies for healthcare assistants across the hospital, with 5.5 vacancies associated with Coleridge Ward.
- The hospital used agency staff to cover vacant shifts. Agency staff covered 544 shifts in the three months prior to our inspection. The highest use of agency was on Coleridge Ward, where they had the most registered nurse vacancies. The hospital reported that all shifts had been filled by bank or agency staff where there was sickness, absence or vacancies in the last three months. The staff turnover rate for the past three months was high at 32%. Staff told us that the recent merger with another provider had contributed to staff leaving the service.
- The hospital recognised that the high vacancy and turnover rate for the hospital had led to an over reliance on bank and agency staff. This was outlined in the hospital risk register and improvement plan. The hospital had made positive steps towards improving the situation. For example, they had introduced three month block booking for agency staff, which helped to ensure consistency to the care and treatment of patients. At the time of inspection, there were eight agency registered nurses on three-month block bookings. The hospital also had ongoing recruitment of registered nurses and had held assessment days in February and March 2018.
- Senior managers had calculated the number and grade of nurses and healthcare assistants required. However, since the provider merger, senior management had reduced the number of registered nurses for the day shift on Coleridge Ward from three to two. Staff reported that two registered nurses on each day shift was not sufficient to meet the needs of the 16-bedded ward.
- The provider must ensure the hospital's governance framework is fully embedded to ensure it is fully effective in identifying risks and areas of improvement. The provider must ensure that governance systems are in place to support senior and ward managers to deliver their roles safely and effectively.
- The data that the hospital provided following the inspection outlined that shifts met planned requirements 100% of the time in the months between January 2018 and March 2018. However, patients and staff felt there was sometimes not enough staff on the wards and also felt an impact from the shortage of permanent staff on the wards. This was because agency staff were not always familiar with the patients and could not always carry out the same tasks as a permanent staff member. Three patients and one staff member said that sometimes patients did not get a fresh air break due to short staffing or agency usage. Patients also said that they were not always able to access the laundry room, computer room and one patient was late for a non-urgent external appointment due to not enough staff being able to take them.
- The staff sickness rate for the hospital in the last three months was 4%.
- The ward managers told us that they could adjust staffing levels to take account of case mix and that there was a formal process in place to do this.
- A qualified nurse was present in communal areas of the wards at all times to help ensure the safety of the patients. Patients said they had regular one-to-one time with their named nurse.
- We reviewed the personnel files of four staff working in the service. These showed that checks were carried out on staff before they started working in the service to confirm that they were suitable to work with patients. This included checks with the Disclosure and Barring Service and at least two references were obtained from previous employers. The service checked prospective employees' qualifications and professional registration.

Medical staff

- There was medical cover day and night and a doctor could attend the ward quickly in an emergency.

Requires improvement

Forensic inpatient/secure wards

Mandatory training

- Most staff had received and were up to date with the hospital's mandatory training. Overall, staff had completed 85% of training. Modules that were below a 75% compliance rate were deprivation of liberty safeguards (DoLS) at 73%, the mental health act (MHA) at 74% and prevention and management of violence and aggression (PMVA) at 71%. The hospital had a low training rate for PMVA as they were in the process of changing the restraint training course from management of violence and aggression (MVA) to PMVA. The hospital had a plan in place to ensure that all staff would be fully trained in PMVA. Managers discussed mandatory training with staff during their supervision to ensure compliance.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed risk assessment of 16 patients. Staff completed risk assessments of patients admitted to the wards. The assessment incorporated historical and known risk information. This information was used to develop risk management plans, which were reviewed regularly and updated after incidents.

Management of patient risk

- Staff understood individual patient risk and how to manage risks identified. Staff followed good policies and procedures for use of observation and for searching patients or their bedrooms. For example, staff searched patients on return from community leave in designated areas. Staff received search training and were required to read the hospital's search policy. Staff were required to store items recovered during searches in the hospital's intelligence folder, which was used during inductions to that new staff were aware of what to look out for.
- Staff applied blanket restrictions on patients' freedom only when justified. This was an improvement from the last inspection in April 2015, where we found a number of inappropriate blanket restrictions in place. Patients on Coleridge Ward could now move between the bedroom area on the first floor and communal areas on the ground floor without asking a member of staff to faciliate it. A hot drinks machine had been fitted on Coleridge Ward to ensure patients had unrestricted access to hot drinks.
- The director of clinical services held monthly reducing restrictive practice meetings with patient representation from each ward.
- The hospital had implemented a smoke-free policy. Staff supported patients to stop or reduce smoking through nicotine replacement therapy. However, patients were still bringing in tobacco from unescorted leave and smoking on the wards. Staff addressed this with patients in community meetings and reducing restrictive practice meetings.

Use of restrictive interventions

- There were 22 incidents of seclusion and one incident of long-term segregation in the last six months. Most of these involved patients from Coleridge Ward, where there were 16 episodes of seclusion. Six episodes of seclusion involved patients from Keats Ward. The hospital had a seclusion policy in place, which included guidance on long-term segregation. The doctor on Coleridge Ward was part of a seclusion reduction programme.
- There were 22 episodes of restraint across the hospital in the last six months. Of those incidents of restraint, one was in the prone (face down) position. The hospital discouraged staff to use the prone restraint.
- The wards participated in the hospital's restrictive interventions reduction programme. Patients had positive behavioural support care plans in place, which is a person-centred approach that staff used to support people who display or are at risk of displaying behaviours that challenge.
- Staff used restraint only after de-escalation had failed and used correct techniques. Staff were trained to use PMVA breakaway. This technique focused on understanding the causes of challenging behaviour, de-escalating aggressive behaviour and emphasizing the use of physical intervention and restraint as a last resort. Seclusion records demonstrated that de-escalation techniques were attempted before seclusion was used.
- The hospital reported that there were no incidents of rapid tranquilisation in the last six months.
- We reviewed three seclusion records that demonstrated staff used seclusion appropriately and followed best practice when they did. For example, staff conducted two-hour nursing reviews and four-hour medical reviews until the first multidisciplinary meeting, in line with the Mental Health Act Code of Practice.

Requires improvement

Forensic inpatient/secure wards

- At the last inspection in April 2015, medical reviews of patients in seclusion did not always take place as frequently as they should during the night, and episodes of seclusion were not recorded clearly. During this inspection, this was no longer the case, medical reviews took place at the frequency required, and seclusion episodes were recorded clearly.

Safeguarding

- Ninety-three percent of staff had received training in safeguarding vulnerable children and adults. Staff had a clear understanding of safeguarding and the process for reporting concerns to the hospital's safeguarding lead. The safeguarding lead had recently provided training to staff on how to raise a safeguarding alert to ensure staff were aware of how to do it in their absence.
- Staff could give examples of how to protect patients from abuse and neglect. Most safeguarding alerts at the hospital involved patient on patient aggression.
- The safeguarding lead attended monthly safeguarding of vulnerable adults meetings at the hospital, which included ward managers, the clinical director of services and a social worker from the local authority. This demonstrated good professional practice in management of abuse in care settings.
- The safeguarding lead had good oversight of the hospital's safeguarding incidents and monitored this via a tracker. There had been eleven safeguardings raised by the hospital between January 2018 and March 2018.
- Staff followed safe procedures for children visiting the ward. The hospital had arrangements in place to safely facilitate family and child visits.

Staff access to essential information

- The hospital had new IT programs in place following the recent merger of the hospital. Ward managers were still getting used to the new systems and sometimes had difficulties in accessing certain information to ensure they had oversight of the ward. This included complaints, ligature risk assessments and the risk register.
- Electronic records contained risk assessments, care records, progress notes and detention paperwork. Some information was recorded on paper, such as seclusion records and handover notes. Staff we spoke to, including agency staff, did not experience difficulties in using these electronic or paper systems.

Medicines management

- Staff followed good practice in medicines management. Ward managers audited medicines weekly to ensure they were managed safely. There was a process for obtaining non-stock medicines out-of-hours from a local pharmacy. Emergency drugs were in date and checked regularly. There were daily checks on fridge temperatures to ensure medicines requiring cold storage were kept at the right temperature. Clinical waste was appropriately disposed of.
- Medicines were stored securely in locked cabinets. There was a locked container in place for patients who were self-medicating in Tennyson House. There were self-medication protocols, care plans and risk assessments in place to safely manage self-medication. If medicines were not given, a code was recorded on the medicine chart explaining the reason for this. At the last inspection in April 2015, on Coleridge Ward, staff had not recorded whether a patient had any allergies on five of 12 medicine records. During this inspection, this was no longer the case and all patients had allergies recorded.

Track record on safety

- There were 225 incidents reported across the hospital from 1 October 2017 to 31 March 2018. The majority occurred on Keats Ward. Incidents on Keats Ward were mainly around aggression and violence. This included a patient who was verbally aggressive and making physical threats towards another patient, and two patients who assaulted two members of staff.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report and gave examples of incidents that had been reported. For example, patient aggression, patients smuggling tobacco onto the wards and personal alarms not working. Staff were de-briefed and received support following a serious incident they were involved in. Reflective practice sessions took place on each ward to enable staff to discuss incidents in a group setting.
- The hospital conducted emergency simulation exercises across the wards to ensure staff took appropriate action in the event of a real life incident.

Requires improvement

Forensic inpatient/secure wards

- We reviewed a sample of incidents. These demonstrated staff understood the duty of candour and were open and transparent with patients if something went wrong.
- There was no formal process to share incident learning with all staff. The hospital did not have an effective system in place for learning and dissemination of incidents to all members of staff. It is important that staff learn from incidents to equip them with the knowledge to prevent similar incidents happening again. Staff we spoke with were not always aware of the learning from incidents across the hospital. Although incidents were discussed regularly at monthly clinical governance meetings and weekly team incident reviews, not all staff could attend these.Team meetings did not happen regularly across the wards, which meant key information was not shared this way.
- Following the inspection, managers informed us that minutes from the clinical governance meetings were now available to all staff on the shared folder on the IT system, and a report was produced and shared following the team incident reviews. In addition, the hospital director was in the process of developing a governance newsletter to share lessons learned with all staff.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff assessed patients' needs and delivered care in line with their individual care plans. We reviewed 16 care and treatment records. All admissions were planned. Pre-admission and admission assessments were undertaken by the multidisciplinary team (MDT) and included an assessment of the individual's risk, mental and physical health. Staff confirmed that all referrals were discussed to ensure the service was suitable.
- Patients were at risk of receiving unsafe care and treatment because physical health monitoring arrangements, in particular for patients with diabetes, were not robust. Blood glucose monitoring and management was not being carried out as detailed in individual care plans. For example, on Coleridge Ward we found that a patient had high blood glucose readings (20+) on three separate occasions. There was no evidence that the concerns had been escalated to doctors or action taken to support the patient safely. On Keats Ward, two patients required blood glucose monitoring to be carried out twice weekly. The last recorded test for one patient was last dated six weeks ago and for a second patient, eight weeks previously. Staff reported that both patients had refused blood glucose monitoring testing butthere were no records detailing the patient's refusal. On Byron Ward blood, glucose monitoring readings had not been taken for a patient that required them twice weekly and for another patient where the blood glucose reading was high there was no evidence that this had been escalated and action taken.
- On Tennyson Ward, a patient required weekly urine analysis testing. Staff had not recorded that this was taking place.
- On Byron Ward, the medication administration record (MAR) for two patients stated that the patients should be monitored for conditions such as constipation, liver function, muscle pain and bladder toxicity. We found no evidence that these areas were being monitored. On Byron Ward, records detailed that blood samples were lost. We found that repeat bloods had not been taken. Staff did not always escalate high national early warning scores (NEWs). The NEWS score for one patient was 4, which indicated clinical deterioration, but there was no record that the physical deterioration of the patient had been escalated. This meant that patients were at risk because physical health monitoring and escalation was not being carried out to meet the individual needs of patients.
- Staff across all the wards developed care plans that met patient needs identified during assessment. Care plans were personalised, holistic and recovery-orientated. The service was proactive in involving people in understanding their condition, setting recovery goals and managing risk collaboratively. For example, on Tennyson House we observed a ward round and saw that patients were involved in discussing their care plan, feedback on progress and any challenges they were facing.

- Where appropriate patients had a positive behavioural support plan. Positive behaviour support (PBS) is a behaviour management system used to understand what triggers and maintains an individual's challenging behaviour. Patients contributed to their own positive behaviour support plan. Plans we viewed contained strategies for staff to follow to keep the person and those around them safe. For example, for two patients their positive behaviour support plans detailed the use of restrictive practices such as the use of restraint to keep them safe. Records showed that both patients had discussed and agreed to this intervention.
- 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.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included medication, psychological therapies and occupational therapy support. On Tennyson House, patients were offered training, education and work opportunities to develop their living skills in preparation for discharge.
- Patients had access to a wide range of psychological therapies including group and individual support. These included dialectical behavioural therapy, cognitive behavioural therapy and mentalisation-based therapy.
- Staff ensured that patients had access to physical health specialists when needed. Patients had access to the visiting GP, optician and dentist when required. Patients were referred to specialist services at the local general hospital and staff supported patients to attend appointments.
- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff monitored patients' weight regularly and a dietician was available to come to the ward to discuss nutrition with individual patients.
- Staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. Patients confirmed that they could access the on-site gym facilities and on Keats Ward, patients participated in a daily exercise workout routine.
- The service used the health of the nation outcome scales (HoNOS – secure) to measure outcomes and improvements in the mental health and social functioning of patients.
- Staff carried out a number of clinical audits on each ward, which included weekly audits of medicine, clinic rooms, environment and emergency equipment. However, we found that staff did not undertake regular and systematic audits to monitor the quality of care records and physical health.

Skilled staff to deliver care

- Care and treatment was delivered by a team of multidisciplinary professionals. These included nurses, health care support workers, occupational therapists, social workers, psychiatrists and clinical psychologists. Dedicated psychology input had not been available on Coleridge Ward and Tennyson House for several months. The lead clinical psychologist reported that patients would receive the therapy they were assessed as requiring.
- Most staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group. However, due to the high turnover of ward managers, the ward managers were new into management roles and in some areas did not demonstrate the required skills, knowledge and experience to perform their roles.
- For example, one manager did not know how to check mandatory training rates on their ward, which meant that they did not have oversight of how many of their staff were up-to-date on training such as safeguarding or restraint. There was a lack of clinical audits at ward level to assure managers of the quality of the wards they ran. However, we were told that the site learning administrator sent out compliance information on a fortnightly basis to all ward managers. In this case, the ward manager was unable to demonstrate knowledge of this

- New staff were provided with appropriate induction. All new staff we spoke with confirmed that they had a comprehensive induction when they joined the service. There was a ward based induction for agency and bank staff.
- Most staff reported that they received regular supervision and could attend reflective practice sessions. However, some staff reported that they did not receive regular supervision in line with the provider policy. For example, on Byron Ward a member of staff had received two supervision sessions since November 2017. This meant that there was a risk that staff were not able to discuss case management, reflect and learn from practice, receive personal support and professional development.
- The percentage of staff that received regular supervision in the last 12 months was 76.4%. The low supervision rates had been identified in the hospital's improvement plan, with actions in place to ensure that regular individual supervision is available to all staff.
- The percentage of staff that had an annual appraisal in the last 12 months was 97%
- Team meeting minutes did not demonstrate that they happened every month as managers said they should For example, Coleridge Ward's last team business meeting was in September 2017 and the last nurses' meeting was in October 2017. On Keats Ward, the last team business meeting was in December 2017. The last nurses' meeting was in March 2018, but there was not date set for a future meeting. On Byron Ward, staff had attended a business meeting on the 13 April 2018. Prior to this, the last recorded meeting was dated 30 January 2018.
- There was a lack of formal meetings to ensure items such as complaints and incidents were shared.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff we spoke with confirmed they had undertaken mandatory training. Preceptorship programmes were available for newly qualified nurses and the service provided a mentoring scheme.
- Staff confirmed that professional development and other training opportunities were offered to develop their skills and knowledge. For example, staff told us they could access specialist training and gave examples of training in personality disorder, substance misuse and relational security.
- Ward managers confirmed that policies and procedures were available to deal with staff performance effectively.

Multidisciplinary and interagency team work

- Wards held regular and effective multidisciplinary (MDT) meetings to review patients' progress and care. Patients were seen on an individual basis at the meetings. We attended one MDT meeting on Tennyson House and observed that the patient was actively involved in their care planning and risk management.
- Staff shared information about patients at effective handover meetings within the team. Handovers took place at the start and end of each shift. The hospital held a daily MDT meeting where any incidents, escalation of patient risk, staffing issues, admissions and discharges were discussed.
- Staff in the service maintained effective relationships with other services and organisations such as social services, police, general practitioners, forensic outreach teams, and employment and education specialists. Staff worked closely with patients' care coordinators in their local areas.

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

- We carried out one Mental Health Act review visit as a part of our inspection of the service. At the time of our inspection there were 51 patients detained under the Act across the fourinpatient wards at the hospital.
- Sixty-nine percent of staff had completed training in the Mental Health Act across the hospital. Staff had a working knowledge about the MHA to support all their patients.
- The MHA administrator post had been vacant for three months and had only been filled prior to our inspection. We found that the current spreadsheet for monitoring patient's detention paperwork, and consequently the paperwork in the administration office, was slightly out

of date as a result. We also found that the recent absence of an administrator had led to some contradictions between what was recorded on the office and what was on the medication charts on the wards.

- Staff had easy access to MHA policies and procedures and to the Code of Practice.
- Patients had limited access to an Independent Mental Health Act advocate (IMHA). An IMHA is an independent advocate who is specially trained to work within the framework of the MHA to support people to understand their rights under the Act and participate in decisions about their care and treatment. Patients received general advocacy support by the National Youth Advocacy Service. The advocate was currently undertaking IMHA training and reported that where required they could refer to an IMHA service, but there were long delays in patients being seen. Advocacy information displayed on the wards did not detail the availability of the IMHA service. This meant that the additional safeguards for detained patients were not in place as detailed in the Code of Practice.
- Staff informed patients about their rights as detained patients and these were repeated at regular intervals in accordance with the MHA Code of Practice.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Detention papers and associated records were available. However, we found that the recent absence of an administrator had led to some contradictions between what was recorded on the office and what was on the medication charts on the wards. The patient records in the office were filed by ward but some recent transfers between wards had not been noted.
- The hospital conducted regular audits of the MHA to ensure staff applied it appropriately. The most recent audit, completed by the Regional MHA Manager on 3 January 2018, identified some significant omissions, which had been followed up by the MHA manager. These audits were presented to the senior management team, which met on a monthly basis.

Good practice in applying the Mental Capacity Act

- Eighty-five percent of staff had had training in the Mental Capacity Act.
- Staff had a working knowledge of the Mental Capacity Act (MCA) and confirmed that capacity was assumed unless proven otherwise. The provider had identified that further staff development and training was required in this area.
- Staff discussed patients' mental capacity and consent to treatment at each ward round. These discussions were recorded and involved the individual patient.
- The service had policies and procedures in place in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). Staff could access these on the intranet.
- When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.
- We saw detailed records relating to the assessment and understanding of capacity across the service where decision specific assessments had been made and the best interests of the individual considered.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed mainly kind, positive and responsive interactions from staff towards patients. We saw a very positive example of a healthcare assistant providing a patient with emotional support and advice at the time they needed it. However, on Coleridge Ward there were limited interactions between staff and patients throughout the time of our inspection.
- Staff supported patients to understand and manage their care and treatment. Patients met with their named nurse weekly and with their multidisciplinary team fortnightly, where care and treatment was discussed.
- We saw evidence that staff directed patients to other services when appropriate. For example, staff referred patients to the dentist, GP and opticians when a need was identified.

Requires improvement

Forensic inpatient/secure wards

- We spoke with 26 patients across the four wards. The feedback was mixed. Some patients were positive about the support they received from staff. They said they felt relaxed and safe on the wards. They said some staff were respectful and caring, and one patient said their doctor was interested in their wellbeing. Patients said they understood why they were taking their medications and felt involved in their care. Some patients said they enjoyed activities offered to them, including the gym, games and community leave. One patient said staff were brilliant and felt able to talk to staff if they had any issues.
- Some patient were negative in their feedback. For example, there were not enough nurses on shift and there were lots of agency staff on shifts, which meant they did not always understand their specific needs. Patients said that they did not always get their set fresh air breaks due to short staffing. Some patients said the wards were not a welcoming environment.
- Staff understood most of the individual needs of patients, including their personal, cultural, social and religious needs. For example, on Tennyson House, we saw good examples where staff supported patients with their sexuality and cultural needs.
- However, it had been recorded in patient community minutes that some patients felt that their religious needs were not being met. Staff addressed this issue with patients in community meeting to remind them that a priest or imam can be made available upon request.

The involvement of people in the care they receive

- Staff used the admission process to inform and orient patients to the wards and the hospital's facilities. Patients were given an information pack, which included information on the ward, how to raise a complaint, explanation of rights under the Mental Health Act and the healthcare professionals looking after them.
- Patients said they felt involved in their care planning. Care records demonstrated that patients were involved in their care plans and risk assessments, and patients were provided with copies of their care plan. Patients chaired daily morning meetings on the wards to plan their activities for the day and were able to raise any concerns or issues.
- On Tennyson House, staff reviewed care plans with patients using an electronic display screen during the patient's ward round.
- The occupational therapy activities programme was adapted to meet the needs of patients and reviewed regularly. Patients were given the opportunity to feedback about the activities in three-month intervals.
- There was a service user liaison role at the hospital. At the time of inspection, four patients filled this role. The service user liaisons chaired the planning meetings every morning and attended the hospital's reducing restrictive practice groups.
- There was positive involvement of ex-patients. An ex-patient was a facilitator at the hospital's recovery college.

Involvement of families and carers

- Staff supported patients to maintain contact with families and carers, which was demonstrated by the care plan 'keeping connected'. This detailed how patients would keep connected with families and carers during their inpatient stay. However, carers fed back that they felt communication between the hospital and themselves was poor.
- The hospital held quarterly carers day events, with the last one held in March 2018. This enabled families and carers to give feedback on the service they received. They were also able to meet the multidisciplinary team involved in the patient's care and treatment and ask any relevant questions.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Bed management

- Average bed occupancy over the last 12 months was over 85%.
- The hospital received referrals from a range of clinical commissioning groups and secure services across the country. Staff maintained contact with local area health and social care teams in order to facilitate discharge

plans closer to the patient's home wherever possible. Patients on Tennyson House had individual flats so they could develop their living skills and live independently in preparation for discharge.

- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. This meant that the patient's allocated room remained vacant whilst they were on leave and until their return to the ward.
- When patients were moved or discharged from a ward, staff told us this happened at an appropriate time during the day.
- Where patients required more intensive support from the low secure and rehabilitation wards, arrangements were in place for them to move to the medium secure wards within the hospital.

Discharge and transfers of care

- The service reported nine delayed discharges over the last six months. Staff reported that delays were due to difficulties in finding suitable community accommodation, funding for care packages and bed availability in other forensic units. All delayed discharges were being managed and reviewed regularly by each ward MDT.
- Care and treatment records showed that staff planned for patients' discharge. Patients were allocated to a care co-ordinator who participated in multidisciplinary meetings and planned discharge arrangements.
- Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital.

Facilities that promote comfort, dignity and privacy

- All patients had their own bedrooms, which could be personalised if they wished. Bathroom and toilet facilities were separate. Doors in rooms used by patients had observation panels with integrated blinds, which could be operated by patients with an override feature for staff.
- Patients could secure their possessions safely. Bedroom
- Some patients reported that the wards did not provide a welcoming environment.
- Staff and patients had access to a range of rooms to support their care and treatment. Including quiet rooms, lounge and dining areas. On Tennyson House, facilities for activities, therapies and cooking were available.
- Visiting arrangements were in place. All visits were booked in advance. Each request was reviewed and risk assessed to ensure a visit was in the child's best interest. All visits were supervised. A separate family/child visiting room was available away from the ward areas.
- Patients could make a phone call in private if needed using a mobile telephone supplied by the hospital or the ward telephone.
- Patients had access to outside space. On Byron, Keats and Coleridge Wards patients could access secure outdoor space, which was used under staff supervision. Patients on Tennyson House had access to their own secure garden.
- Patients reported that the food was of good quality. Meals were prepared on site by the catering team and food options were available. On Tennyson House, occupational therapists supported patients with meal planning and preparation as part of their skills development and recovery support plan. A patient we spoke with confirmed that they had been supported to develop their skills in this area and they could now cook independently.
- Drinks and snacks were available for patients throughout the day and night. Fruit was available for snacks in the kitchen or dining rooms.

Patients' engagement with the wider community

- All patients had access to a comprehensive occupational therapy and recovery college programme to support them with their therapeutic, education and employment needs. This included, one-to-one, group, indoor and outdoor activities. The therapies programme was co-produced with patients and reviewed every three months. Maths and English tutors came into the hospital and provided individual tutorials to improve patients' literacy and numeracy skills. Where appropriate, an enablement worker was allocated to patients on Tennyson House as part of their recovery plan.

Requires improvement

Forensic inpatient/secure wards

- The hospital offered 20 re-work positions that patients could apply for across the hospital site. These were paid positions in gardening, the hospital shop and supporting with decoration. Patients were required to complete an application form and attend an interview.
- Staff supported patients to maintain contact with their families and carers and other people that mattered to them. Care records showed that staff regularly communicated with families and visits were arranged where appropriate.

Meeting the needs of all people who use the service

- The hospital wards were not easily accessible to patients with mobility needs due to the nature of the building. Tennyson House had some bedrooms on the ground floor that enabled access for those with a physical disability.
- Staff gave patients and carers information about the service and how to get advice and support. They could get information for patients and carers translated if necessary. However, for a patient on Tennyson House the care plan indicated that pictures and diagrams should be used to support them understand their care and treatment. We found that information was not being presented in this way.
- Patients whose first language was not English had access to interpreters who could support patients to understand their care and treatment, including their legal status. For example, we saw that an interpreter had been used during a CPA meeting to support the patient and their family to understand the care and treatment plan.
- The service was able to provide a choice of food that met the dietary requirements of differing religious and ethnic groups.
- Staff ensured that patients had access to appropriate spiritual support. The hospital had a spiritual room, which patients used. Visits by spiritual leaders were arranged by staff upon patient request. The service was responsive to people's individual needs, for example, the occupational therapy team adjusted group times to accommodate Muslim prayers.

Listening to and learning from concerns and complaints

- In the last six months, the hospital had investigated 18 complaints. The patient safety lead reported that any service dissatisfaction reported by the patients were logged as a complaint. Where possible, staff addressed complaints at ward level and agreed any resolution with the individual patient.
- Patients knew how to complain or raise concerns. Complaints information was displayed throughout the service and in the patient information pack. Patients complained directly to staff, or raised their concerns at the daily planning meeting. The patient safety lead ran a regular clinic on the wards, which also enabled patients to provide feedback and raise concerns. Patients reported that staff would deal with their concerns and they would be protected from discrimination or harassment.
- When patients complained or raised concerns, they received feedback. For example, where a resolution had been reached and agreed the patient was encouraged to sign the complaint record.
- Staff knew how to handle complaints appropriately and sought advice from the patient safety lead and ward managers if required.
- Staff reported that they did not always receive feedback on the outcome of complaints investigations or know of any changes to practice following complaints made.

Are forensic inpatient/secure wards well-led?

Requires improvement

Leadership

- The senior leadership team had an unstable period following the Priory Group merger in December 2016. Most leaders were relatively new into their role at the time of the inspection. For example, the hospital director was three weeks into post. Since May 2017, there had been three different hospital directors in post at the hospital. Senior managers and staff recognised that this had been a challenging time for the service. However, the current hospital director demonstrated they had the skills, knowledge and experience to perform their role.

- There had been a high turnover of ward managers, which meant there was a lack of leadership and experience at ward level. The managers were new into management roles and in some areas did not demonstrate the required skills, knowledge and experience to perform their roles. For example, some managers were unable to find key documents such as ligature risk assessments, complaint and mandatory training information. Some managers lacked knowledge on the duty of candour, equality and diversity and could not identify the risks on the risk register for their ward.
- Managers knew they needed to develop leadership in the hospital, and had implemented a ward management development programme to address the needs identified.
- Leaders were visible in the service and approachable for patients and staff. For example, the hospital director attended a regular staff listening group and the director of clinical services chaired monthly reducing restrictive practice with the service user liaison representatives.

Vison and strategy

- Staff knew about and understood the values of the organisation, which were called 'our purpose and behaviours'. The purpose was 'to make a real and lasting difference to everyone we support'. The behaviours were putting people first, being a family, acting with integrity, being positive and striving for excellence. We saw examples of the values being put into practice throughout the hospital. The hospital director was in the process of setting out the strategic vision for the hospital.
- Senior managers had been proactive in engaging with staff since the Priory Group merger to ensure they could contribute to discussions about the strategy for the service. 'your say' forums had recently been introduced so staff could raise issues with senior management.

Culture

- Recent staff survey results indicated that staff morale was low and some staff did not feel listened to. For example, 45% of staff did not want to be working at the hospital in two years' time, and 49% of the staff felt valued and recognised for the work that they did. Forty-nine percent of staff did not believe that action would be taken as a result of the survey. Staff also gave feedback that they felt staffing levels on the wards were low. However, staff consistently said there was good team working on the ward.
- We received mixed feedback from staff about working for the provider. Some staff said morale was low due to the recent provider merger and consequently there had been a high turnover of staff and high agency use. Staff said the instability of management at ward and senior level had been difficult. Staff said it had taken time for them to understand the new IT systems and processes that were in place following the merger.
- However, the hospital was aware of this issue and had identified it on the hospital's risk register. The hospital had plans in place to improve staff morale, for example, the hospital director produced weekly newsletters with updates on the hospital, and held regular staff listening groups as a way for staff to communicate with senior management. The hospital also had plans to hold staff working groups, inviting staff from all levels to work on key areas such as recruitment and the environment.
- Staff felt able to raise concerns without fear of retribution.
- Staff knew how to use the whistleblowing process. The wards had a whistleblowing policy in the nursing office that detailed a whistleblowing helpline.
- Teams said they worked well together. However, some staff said that nursing staff and therapy staff often worked in isolation, and improvements could be made to work in a more multidisciplinary way.
- Staff appraisals included conversation about career development and how it could be supported. For example, a nurse on Byron Ward had been encouraged to apply for a promotion through this process.
- Staff had access to support for their own physical and emotional health needs through an employee assistance helpline.
- The hospital recognised staff success within the service. For example, staff could nominate other staff members for a 'making a difference' recognition award.

Good governance

- The hospital had a governance framework in place, but it was not yet embedded or effective in identifying risks and areas of improvement following the change in provider in December 2016. For example, ward managers were still getting used to the new IT programs

and were not always able to access key information to ensure they had oversight of the wards they managed, including complaints, mandatory training data and risk register information.
- Due to the high turnover of ward managers, it meant current ward managers were inexperienced and did not always have the knowledge to deliver their management role effectively. Most ward managers were new in management roles, and all wards had deputy ward manager vacancies, which meant ward managers lacked managerial support on the wards. Ward managers did not hold regular team meetings to ensure essential information was shared and discussed.
- Staff did not undertake regular and systematic audits to monitor the quality of care records and physical health.
- Ward managers did not carry out the necessary checks to assure themselves that the ward was safe. This included checking that wall alarms were working. A patient on Keats Ward told us that some of the wall alarms had not been working for a long time and pressed one of the wall alarms during our tour of the ward, which demonstrated that it did not work. This was raised with management during our inspection, who clarified that the correct checks had not been completed.
- Ward managers lacked sufficient administration support to do their role. There was only one full-time administrator for the four wards, and they were responsible for booking bank and agency.
- The hospital had not ensured there was a robust oversight of the mental health act (MHA) administration during the three-month period when there was no MHA administrator in post.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. For example, staff worked well with the local authority to ensure safeguardings were managed appropriately.

Management of risk, issues and performance

- The hospital maintained a risk register for the hospital, which the management team reviewed at senior management meetings. Some ward managers could not access the risk register and were unaware of the risks on the risk register that related to their wards.
- Staff concerns matched those on the risk register. For example, high turnover of staff, high use of agency, low staff morale and the environment. Senior management reviewed and updated the risk register in clinical governance meetings. The hospital had developed an improvement plan to ensure they improved in the areas identified on the risk register. There were timescales for completion of actions.
- The hospital had plans for emergencies. For example, adverse weather or a flu outbreak.

Information management

- The service used systems to collect data from wards that were not over-burdensome for frontline staff.
- However, due to the recent merger of the hospital, it was taking ward managers time to get used to the new IT systems that were in place. The new IT systems were not yet fully embedded and ward managers did not always know where to locate information to ensure oversight of the ward. For example, some ward managers did not know how to use the hospital's dashboard to view the ward's mandatory training rates, this meant they could not be assured that all staff were up to date on key training.
- In addition, IT systems did not always pull through live data onto the dashboard that listed patient care record information. Ward managers assured inspectors that certain information that was showing up as requiring action was actually met. For example, on Keats Ward, the dashboard was showing that some patients did not have assigned primary nurses, but the ward manager assured us that they did. The current systems did not provide the correct assurances.
- Information governance systems included confidentiality of patient records. However, on Coleridge Ward we found that confidential papers were not stored securely and were stored in an open basket under the desk in the nurse's office. This was highlighted to management following the inspection who informed us that all wards have been supplied with confidential bags for any waste paper with confidential information. The bags were always available and this had been an individual error.
- Staff made notifications to external bodies as needed, such as to the Care Quality Commission and the local authority.

Engagement

- The hospital director sent weekly newsletters to staff to keep them up-to-date on the work of the hospital.

Requires improvement

Forensic inpatient/secure wards

- Staff had opportunities to give feedback on the service. One example was through monthly 'your say forums' facilitated by senior management. Another example was through annual employee engagement surveys.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients fed back on the service through the community meetings and carers could do this through the weekly carer support groups held.
- Managers had access to the feedback from patients and carers, and used it to make improvements. For example, carers gave feedback at the recent carer's day event, and said there was poor communication between them and the hospital. The hospital director included this feedback in the weekly newsletter and reminded staff about the importance of communicating with families, for example following an incident.
- Staff completed staff surveys to provide feedback on the quality of support they received from management.
- Staff met with senior management team to give feedback via regular staff listening meetings.
- Senior management engaged with external stakeholders, such as commissioners.

Learning, continuous improvement and innovation

- Staff were given the time and support to feedback on the service through the recent introduction of staff listening groups. However, as these groups had only recently started, time was needed to see if staff feedback led to service changes.
- The hospital did not use quality improvement methods or participate in research.
- The hospital participated in national audits relevant to the service, for example, the national schizophrenia audit.
- The hospital participated in a nationally accredited quality improvement programme for forensic inpatient services. The purpose of this accreditation was to improve care for inpatient mental health wards in the United Kingdom and work towards a purposeful admission within the context of a safe and therapeutic environment.

Outstanding practice and areas for improvement

Outstanding practice

The hospital was proactive in reducing restrictive practice. The director of clinical services held monthly reducing restrictive practice meetings with patient representation from each ward to discuss how the hospital could improve restrictive practice, such as eliminating blanket restrictions.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the hospital's governance framework is embedded to ensure it is fully effective in identifying risks and areas of improvement. The provider must ensure that governance systems are in place to support senior and ward managers to deliver their roles safely and effectively.
- The provider must ensure that physical health monitoring is carried out to meet the individual needs of patients. The provider must ensure there is an effective oversight of physical health monitoring system within the hospital.
- The provider must ensure there are effective systems in place for learning and dissemination of incidents and complaints to all staff. The provider must ensure staff engage with patients following a seclusion episode to provide patients with a de-brief and any additional support.
- The provider must ensure that patients subject to the Act have access to Independent Mental Health Advocate (IMHA) provision, as required in the Mental Health Act Code of Practice. The IMHA should not be replaced with a generic advocate who is not IMHA qualified.

Action the provider SHOULD take to improve

- The provider should ensure that there are enough personal alarms for staff and they are in working order.
- The provider should ensure that the environment on Coleridge, Keats and Byron Ward is therapeutic and well maintained, in line with the environmental work set out in the hospital's estates plan.
- The provider should continue to ensure steps are taken to ensure familiar staff are working across the wards to ensure consistency to patients' care and treatment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care and treatment was not always provided in a safe way. Physical health monitoring was not being carried out to meet the individual needs of patients. Blood Glucose monitoring was inconsistent, physical health conditions in relation to medicines were not monitored and staff did not always escalate clinical deterioration. The provider did not ensure there were effective systems in place for learning and dissemination of incidents and complaints to all staff. The provider did not ensure staff engaged with patients following a seclusion episode to provide patients with a de-brief and any additional support. This was a breach of 12 (1) (2) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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Requirement notices

Since the merger, the governance framework was not fully embedded or effective in identifying risks and areas of improvement. There had also been a high turnover of senior managers and ward managers since the merger, which had led to inconsistent leadership at the hospital and a lack of experience and knowledge to effectively deliver managerial roles.

Senior management did not ensure that there were provisions in place to ensure that detained patients had access to an IMHA as required by the Mental Health Act.

This was a breach of 17 (1) 2) (a) (b) (c)