Outstanding ☆

Sheffield Health and Social Care NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

Fulwood House
Old Fulwood Road
Sheffield
South Yorkshire
S10 3TH
Tel: 0114 271 6310
Website: www.sct.nhs.uk

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Forest Lodge	TAHXN	Assessment ward Rehabilitation ward	S35 OJW

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

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

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

Summary of findings

Ratings

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

Overall rating for forensic inpatient / secure wards	Outstanding ☆
Are forensic inpatient / secure wards safe?	Good ●
Are forensic inpatient / secure wards effective?	Outstanding ☆
Are forensic inpatient / secure wards caring?	Outstanding ☆
Are forensic inpatient / secure wards responsive?	Good ●
Are forensic inpatient / secure wards well-led?	Outstanding ☆

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

Overall, the wards provided a clean, safe environment for patients requiring care and treatment within a low secure setting. Staff effectively assessed and monitored environmental and individual patient risks to help keep patients and staff safe. This was reflected in the relatively low use of restraint, seclusion and number of serious incidents which have occurred on the wards over the past year.

We found the management, administration and storage of medicines was safe. On the rehabilitation unit, there were robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

We found many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers. The wards were sensitive and respectful in providing care and treatment which met patients' cultural, social, educational, physical, psychological and spiritual needs. There was an excellent range of recreational and therapeutic activities and facilities to support patient's recovery. This was enhanced by external support links the wards had developed with local faith leaders, specialist advocates, Sheffield College and the Open University. Examples of this included a patient involved in voluntary work for a local charity whilst on leave and another patient who had completed 'O' levels maths with the help of a tutor who visited them weekly on the ward.

The service had also set up joint training for patients and staff to attend on risk assessments.

The wards shared a philosophy of care focussed upon the principles of the recovery model with restrictions were kept to a minimum. Patients were supported to maintain contact with their relatives through use of technology such as SKYPE and mobile phones where appropriate.

We spoke with 14 out of 22 patients during our visit. Without exception, all the patients we spoke with talked very positively about the attitude of the staff caring for them. They said they felt fully informed and involved in decisions about their care and treatment. They were able to discuss their care plans with us and plans for their future.

We found several examples which demonstrated that staff took every opportunity possible to involve patients and their carers in the care and treatment they received from admission to discharge. This included developing and reviewing plans of care and risk assessments with their named nurse to attendance at MDT/CPA meetings. Following each CPA meeting, patients' were shown a copy of the draft CPA documentation and were given the opportunity to add their views before it was finalised.

There was effective multi-disciplinary team (MDT) working within the teams with the full involvement of patients, their relatives and advocates. In MDT meetings, each member provided a weekly summary of the patient's progress to the team which was projected onto a screen for all to view. The discussion and outcome of the MDT meeting was up-dated onto the screen in 'real time'. Discharge was planned from point of admission under the framework of the Care Programme Approach (CPA) in line with best practice.

The teams demonstrated good compliance with the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA).

Staff morale was high and there were sufficient numbers of staff to meet patient's needs'. The teams were committed to continuous improvement and development. They had achieved 100% compliance with the trusts' compulsory training, staff appraisals and clinical supervision. Staff had access to specialised training and teams to support their work in line with National Institute of Clinical and Health Excellence (NICE) guidance.

The wards had strong local governance arrangements in place to monitor the quality of service delivery through a range of internal and external audits.

Both wards were members of the Royal College of Psychiatrists Forensic Quality Network for Mental Health Services. The quality network reviews services against criteria which have been developed from the Department of Health's Best Practice Guidance. This demonstrated the wards were open to external scrutiny.

Summary of findings

The wards had a 'fast track' complaints system in place which enabled patients or visitors to raise an informal complaint if they did not wish to make a formal complaint.

There were some issues we found in relation to the environment and seclusion room which we were assured would be addressed. These included a bathroom which had been decommissioned which was used as a store room and the need to upgrade the observation panel in the seclusion room door. The disabled access shower room on the rehabilitation ward did not have an alarm or call system in place to enable patients to call for assistance.

Summary of findings

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

Are services safe?

Good

Overall, the wards provided a clean, safe environment for patients requiring care and treatment within a low secure setting. Staff effectively assessed and monitored environmental and individual patient risks to help keep patients and staff safe. This was reflected in the relatively low use of restraint, seclusion and number of serious incidents which have occurred on the wards over the past year.

The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs.

The management, administration and storage of medicines was safe.

Incidents which occurred were reported appropriately and analysed. Learning lessons took place and changes in practice were implemented in response to these.

There were a number of ligature risks within the ward environment, where patients may have been unsupervised by staff. These included internal bedroom door handles, taps and communal toilets. These risks had been identified and there was an action plan in place to reduce or mitigate the risks. However, removal of these ligatures would further reduce the risks.

The disabled access shower room on the rehabilitation ward did not have an alarm or call system in place to enable patients to call for assistance.

The seclusion room met most of the requirements of the MHA 1983 Code of Practice although the observation panel in the door was solid which made effective communication between staff and patients using the room difficult. We were given assurance that plans were in place to address this.

Are services effective?

Outstanding

We have judged the service as outstanding in this area as there were many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers in line with the National Institute for Health and Clinical Excellence (NICE) and national guidance.

There were some excellent examples of how the teams were meeting patients educational, social and psychological needs by working in partnership with external organisations.

Summary of findings

There was effective multi-disciplinary team (MDT) working within the teams with the proactive involvement of patients, their relatives and advocates in accordance with the patient's wishes. Each member of the MDT provided a weekly summary of the patient's progress to the team. These were projected onto a screen for all to view. The discussion and outcome of the MDT meeting was up-dated onto the screen in 'real time'.

Discharge was planned from point of admission under the framework of the Care Programme

Approach (CPA) in line with best practice. Following each CPA meeting, patients' were shown a copy of the draft CPA documentation and were given the opportunity to add their views before it was finalised.

On the rehabilitation unit, the team had worked with the pharmacy team to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

The teams had achieved 100% compliance with the trusts' compulsory training and staff appraisals. Staff accessed specialised training and clinical supervision to support their work.

The teams understood and adhered to the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA).

Are services caring?

Outstanding ☆

We have judged the service as outstanding in this area. This was because despite being detained under the Mental Health Act (MHA), there was a culture of empowerment and trust between patients, carers and staff.

All the patients we spoke with told us that staff treated them well and they were making good progress on the ward they were staying. They all spoke very positively about the attitude of the staff caring for them and felt fully informed and involved in decisions about their care and treatment. They were able to discuss their care plans with us and plans for their future.

Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act.

We found several examples which demonstrated that staff took every opportunity possible to involve patients and their carers in the care and treatment they received from admission to discharge. This included developing and reviewing plans of care with their named nurse to attendance at MDT/CPA meetings.

Summary of findings

The teams actively supported patients and their relatives to keep in contact with technology such as video conferencing, allowing patients to have their own mobile phones where this was safe to do so and supporting visits from relatives. The service also provided support to patients' relatives and carers within an established relatives support group.

The service had set up joint training for patients and staff to attend on risk assessments to promote learning. The wards held fortnightly community meetings which all patients were encouraged to attend.

Are services responsive to people's needs?

Good

We have judged the service as good in this area as the wards proactively promoted patients' recovery from admission through to discharge. They achieved this by ensuring each patient had access to the facilities and therapies they needed to assist them in the current stage of their recovery. The wards shared a philosophy of care focussed upon the principles of the recovery model. Staff took all practical steps to minimise restrictions on patients where possible, despite the low secure requirements of the service and legal restrictions imposed on patients.

Ward staff were sensitive and respectful in providing care and treatment which met patient's cultural, social, physical, psychological and spiritual needs. They offered an excellent range of recreational and therapeutic activities and facilities to support patient's recovery which were available seven days a week including evenings. This was also enhanced by external support links the wards had developed with local faith leaders, specialist advocates, Sheffield College and the Open University.

Discharge was planned from point of admission and reviewed regularly through patients' multi-disciplinary team (MDT) and care programme approach (CPA) meetings.

Despite the difficulties the service faced securing suitable accommodation for some patients due to their complex needs' and past offending behaviour; every patient had a discharge plan in place.

The average length of stay on the wards was 18 months which is lower than average when compared to similar services. The lack of re-admissions post discharge from the wards provided evidence to show that the discharge process was effective and patients received the support they needed.

The wards had a 'fast track' complaints system in place which enabled patients or visitors to raise an informal complaint if they did

Summary of findings

not wish to make a formal complaint. Patients were given information and support about how they could raise a formal complaint or provide feedback through the patient advice liaison service (PALS), advocacy or directly to the trust.

Are services well-led?

Outstanding ☆

The wards provided care and treatment which was underpinned by the principles of the recovery model which was in line with the trust vision and values. Staff were committed, highly motivated and proud of their work and the teams they worked within.

The wards had strong local governance arrangements in place to monitor the quality of service delivery through a range of internal and external audits. These included risks, incidents, complaints, compliments, infection control, medication, Mental Health Act monitoring and security issues.

The wards proactively sought feedback from patients to improve the service.

Staff participated in a number of forums focused on improving practice which included staff meetings, group supervision, away days and governance meetings.

Staff told us the senior managers on the ward were visible, approachable and had an 'open door' policy. Managers ensured that compliance with mandatory training, appraisals and supervision was maintained by all staff members.

Both wards were members of the Royal College of Psychiatrists Forensic Quality Network for Mental Health Services. The quality network reviews services against criteria which have been developed from the Department of Health's Best Practice Guidance. The wards were peer reviewed by the network in January 2014 and have implemented all the recommendations made by the network since. This demonstrated the wards were open to external scrutiny and responsive in making positive changes to the service based on feedback received.

Summary of findings

Background to the service

Sheffield Health and Social Care NHS Foundation Trust provide forensic and secure inpatient services for men aged 18 years and over with mental health conditions which require management under conditions of locked low security. The trust has two low secure wards which are based at Forest Lodge.

Services

Forest Lodge unit comprises of an 11 bed assessment and treatment ward for males and an 11 bed rehabilitation ward for males.

Forest Lodge was inspected by CQC inspectors in February 2014 and judged to be compliant with the essential standards of quality and safety. A Mental Health Act reviewer also undertook a MHA monitoring visit to both wards in May 2014.

Our inspection team

Our inspection team was led by:

Chair: Alison Rose-Quirie, Chief Executive Officer, Swanton Care.

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included CQC inspectors, a mental health act reviewer looking at the rights of patients sectioned under the Mental Health Act 1983, a variety of specialists including a consultant psychiatrist, a community mental health team manager, a nurse, pharmacist, a social worker and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 a range of information we held about the core service and asked other organisations to share what they knew. We also held focus groups for patients.

We carried out an announced visit on 27 October through to 31 October 2014. During the visit the inspection team:-

- Held focus groups with a range of staff that worked within the service, such as senior managers, doctors, nurses, support workers and allied health professionals.
- Spoke with 10 staff on the two wards we visited, which included consultants psychiatrists, ward managers, qualified nurses, care support workers and occupational therapists.
- Observed how patients were being cared for on the two wards.
- Reviewed eight care records and each patient's prescription chart.
- Talked with 14 patients who shared their views and experiences of the low secure service with us.
- Attended one multi-disciplinary team patient meeting and one staff ward handover.
- Left comment boxes on the wards for patients to leave feedback for us.

Summary of findings

What people who use the provider's services say

Despite being detained under the Mental Health Act, all 14 patients we spoke with told us that staff treated them well and they were making good progress on the ward they were staying. They all spoke very positively about the attitude of the staff caring for them and felt informed and involved in decisions about their care and treatment.

Good practice

- Each member of the multi-disciplinary team (MDT) provided a weekly summary of the patient's progress to the team. These were projected onto a screen for all to view. The discussion and outcome of the MDT meeting was up-dated onto the screen in 'real time'.
- Following each CPA meeting, patients' were shown a copy of the draft CPA documentation and were given the opportunity to add their views before it was finalised.
- On the rehabilitation unit there were robust step down procedures to support patients in managing their own medicines.
- The service had set up training for patients and staff to attend on risk assessments to promote joint learning.
- The wards had a 'fast track' complaints system in place which enabled patients or visitors to raise an informal complaint if they did not wish to make a formal complaint.
- There was an excellent range of recreational and therapeutic activities and facilities to support patient's recovery. This was enhanced by external support links the wards had developed with local faith leaders, specialist advocates, Sheffield College and the Open University.
- Patient's had access to SKYPE and mobile phones if appropriate to keep in touch with family.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The seclusion room observation panel should be replaced with one which enables effective communication between staff and patients.
- The provider should ensure there is a way for a patient using the disabled access shower room on the rehabilitation ward to call for assistance if needed.
- The provider should review and remove all ligature risks where patients have unsupervised access.

Sheffield Health and Social Care NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Assessment ward Rehabilitation ward	Forest Lodge

Mental Health Act responsibilities

The mental health act reviewer looked at the rights of patients detained under the Mental Health Act (MHA) on both wards we visited. They found that Mental Health Act (MHA) documentation was present and available for inspection and was in order. Section renewals had been made in good time.

Patients were aware of their rights under the MHA and there was evidence that these were repeated at regular intervals. Independent Mental Health Advocate (IMHA) services were routinely offered and were provided through Sheffield Mental Health Advocacy Services.

We found evidence that patients' capacity to consent or dissent to treatment was assessed and documented in line with the Mental Health Code of Practice (CoP). On the sample of patients' prescription charts we looked at, there were no discrepancies between medications being administered and medication listed on the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms.

We found that there was a standardised process in place for authorising leave under section 17 of the MHA. Copies of leave forms had been given to patients and others as per the MHA CoP in the majority of cases. Risk assessments had been completed prior to leave being taken and were recorded in patients' notes. There was also evidence of a review of leave afterwards detailed in patients' care records.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All of the patients on both wards were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were made under the legal framework of the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues.

Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

Staff took all practical steps to involve patients and their carers or advocates in decisions regarding their care and treatment.

Good

Are services safe?

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

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

Summary of findings

Overall, the wards provided a clean, safe environment for patients requiring care and treatment within a low secure setting. Staff effectively assessed and monitored environmental and individual patient risks to help keep patients and staff safe. This was reflected in the relatively low use of restraint, seclusion and number of serious incidents which have occurred on the wards over the past year.

The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs.

The management, administration and storage of medicines was safe.

Incidents which occurred were reported appropriately and analysed. Learning lessons took place and changes in practice were implemented in response to these.

There were a number of ligature risks within the ward environment, where patients may have been unsupervised by staff. These included internal bedroom door handles, taps and communal toilets. These risks had been identified and there was an action plan in place to reduce or mitigate the risks. However, removal of these ligatures would further reduce the risks.

The disabled access shower room on the rehabilitation ward did not have an alarm or call system in place to enable patients to call for assistance.

The seclusion room met most of the requirements of the MHA 1983 Code of Practice although the observation panel in the door was solid which made effective communication between staff and patients using the room difficult. We were given assurance that plans were in place to address this.

Our findings

Safe and clean ward environment

Access and exit from the wards was controlled by staff. There was an air locked door which ensured that only authorised people were allowed to access and leave the building to make sure patients were kept safe. The outside garden space had the appropriate level of fencing required for a low secure facility. Each ward had a designated security nurse per shift who carried out regular, documented environmental checks on the wards to make sure there were no breaches in security. Staff we spoke with understood the key messages from 'See, Think, Act' which is the Department of Health national guidance on maintaining appropriate security within mental health secure settings. New staff received a comprehensive induction which included all aspects of security on the wards. They were given a set of keys only when their induction booklet was signed off. All keys were accounted for twice daily.

The wards undertook annual ligature risk assessment audits. These were extremely detailed and covered all areas of the ward and identified all ligature risks. However there were a number of ligature risks within the ward environment where patients could be unsupervised which included internal bedroom door handles and taps. Where a risk had been identified, there was an action plan in place to reduce or mitigate the risk. This included restricting patient access to rooms and increasing observation levels if a patient was assessed as at risk of self-harm.

Some ward doors had red dots placed on them. Staff told us this was to remind them these doors needed to be kept locked at all times as patients were not allowed unsupervised access to these rooms due to safety reasons. All the wards and bedroom doors opened outwards to reduce the risk of them been used as a barricade.

The assessment ward had a seclusion room which met most of the requirements of the Mental Health Act 1983 (MHA) Code of Practice (CoP) in relation to providing a safe environment for the management of patients presenting as a risk to others. This included appropriate ventilation, heating and lighting which were managed remotely. There were good lines of sight, with 'blind spots' remedied by the use of a curved mirror.

A minimum of one member of staff was present outside the room at all times during its use. However there was no

means for patients and staff to communicate with each other effectively. The seclusion room door had a clear panel which was used by staff to observe patients. The panel was solid. As the seclusion room was located at the end of one of the bedroom corridors not far from the communal areas, the reliance on calling through the closed door did not maintain patients' privacy and dignity as per the CoP. The manager told us the panel was due to be replaced and they would explore alternative options available with the aim of resolving this issue. There was no clock visible from the seclusion room. Staff told us that they would inform patients of the time upon request. The manager informed us they would arrange for a clock to be installed outside of the room to enable patients could independently orientate themselves to time.

The seclusion en-suite toilet could only be opened by staff entering the seclusion room as the door was solid, kept locked and could not be opened externally. Staff told us any patient using the toilet would be observed by staff at all times. This meant the door would be kept ajar. The seclusion room was opposite a bathroom at the end of a communal corridor. Staff told us they maintained the privacy and dignity of patients by 'screening off' access to the bathroom and seclusion room whilst the en-suite in seclusion was in use.

Overall, the wards provided a clean and well maintained environment for patients. All staff had completed training in infection control. The clinic rooms in each ward were generally clean and tidy apart from an oxygen cylinder and trolley which were dusty on the rehabilitation ward. The manager told us they would ensure these were cleaned on the day of our visit.

The disabled access shower room on the rehabilitation ward did not have an alarm or call system in place to enable patients to call for assistance.

We found the management, administration and storage of medicines was safe. Controlled drug records were fully completed and accurate.

Safe staffing

The wards had sufficient numbers and the appropriate skill mix of staff on duty at all times to meet patients' needs. The consultant psychiatrist and ward doctors attended the wards each week day. Out of office hours, there was an on call system in place for medical cover. Staff and patients told us there were no problems accessing a doctor when required. The wards did not have any significant staffing vacancies or sickness levels. The manager said they had the authority to increase staffing levels in response to increased clinical risks or unplanned sickness to maintain the safety of patients and staff on the wards. Where possible, permanent staff covered any staffing vacancies. Bank and agency staff were not allowed to work on the wards unless they had completed an induction. The wards requested bank staff who had worked on the ward before to promote continuity of care.

Patients told us that ward activities or planned leave were rarely cancelled due to staff issues and where this had occurred, it was due to staff dealing with an emergency situation.

One patient on the assessment ward told us "There is always someone around. There is never any problem getting hold of a member of staff in here."

Assessing and managing risk to patients and staff

The wards had embedded systems in place to assess and monitor risks to individual patients and staff. Visitors were made aware of the policies regarding the searching of visitors and banned items which were not permitted on the wards before being allowed to access the ward areas. Staff and patients we spoke with were able to explain the conditions under which searches could take place which reflected the trust policy.

All staff on the wards were provided with personal alarms. Staff we spoke with told us that the wards were very good at responding if they needed assistance or someone activated an alarm. The seclusion room on the assessment ward had been used 10 times in the previous six months. Staff were trained to use de-escalation techniques to effectively prevent or manage incidents on the wards in addition to the prevention of violence and managing aggression training (PVMA). Over the previous six months, there had been eight episodes where restraint had been used on the assessment ward. One of these involved the use of 'prone' (face down) restraint for a short time whilst rapid tranquilisation was administered. There had been no use of either on the rehabilitation ward. Staff told us they were committed to providing care in the least restrictive environment which accounted for the relatively low usage of the seclusion room and restraint.

Each patient had a detailed risk assessment which was reviewed every six weeks as a minimum or response to any

Good

Are services safe?

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

incidents or changes in their behaviour. Where a risk had been identified, a care plan was in place to reduce or manage the risk. We saw evidence showing risk assessments and care plans of patients involved in any incidents, were updated in a timely manner and appropriate action was taken to manage potential future risks.

The wards had accessible equipment to deal with possible medical emergencies such as defibrillators, oxygen and first aid bags which staff were all trained to use. Appropriate checks of these were maintained and recorded.

All staff had received training in safeguarding adults and children. They were knowledgeable about the process for making safeguarding referrals and some staff gave us examples of when they had done so.

Reporting incidents and learning from when things go wrong

The wards had an electronic incident reporting system which was completed following any incidents. This allowed the ward manager to review and grade the severity of incidents. Staff all knew how to use the system and what their responsibilities were in relation to reporting incidents.

Since 2004, trusts have been encouraged to report all patient safety incidents to the national reporting and learning system (NRLS) and since 2010, it has been mandatory for them to report all death or severe harm incidents to the CQC via the NRLS. There had been one serious untoward incident reported in past 12 months which had occurred at Forest Lodge. This had involved several members of staff being injured by a patient. Staff told us they were supported fully by the manager on the ward following this incident which included psychology led de-briefing sessions. The outcome of the investigation was discussed with staff. This had identified some issues in relation to the recent changes in the prevention of violence and management of aggression (PVMA) training. In response to this, a review of the PVMA training was taking place and the issues had been included on the risk register for the service.

Incidents which occurred were analysed by the ward manager to identify trends. The wards held regular ward meetings with staff and agenda items included safeguarding, learning from incidents and safety alerts. Minutes were made available to staff unable to attend the meetings.

Handovers took place to ensure that on-coming staff were made aware of any incidents which had taken place on the ward, who had been involved and the outcome the incident.

Are services effective?

Outstanding ☆

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

Summary of findings

We have judged the service as outstanding in this area as there were many examples of how the wards had integrated best practice within the care and treatment they provided to patients and their carers in line with the National Institute for Health and Clinical Excellence (NICE) and national guidance.

There were some excellent examples of how the teams were meeting patients educational, social and psychological needs by working in partnership with external organisations.

There was effective multi-disciplinary team (MDT) working within the teams with the proactive involvement of patients, their relatives and advocates in accordance with the patient's wishes. Each member of the MDT provided a weekly summary of the patient's progress to the team. These were projected onto a screen for all to view. The discussion and outcome of the MDT meeting was up-dated onto the screen in 'real time'.

Discharge was planned from point of admission under the framework of the Care Programme

Approach (CPA) in line with best practice. Following each CPA meeting, patients' were shown a copy of the draft CPA documentation and were given the opportunity to add their views before it was finalised.

On the rehabilitation unit, the team had worked with the pharmacy team to develop and implement robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

The teams had achieved 100% compliance with the trusts' compulsory training and staff appraisals. Staff accessed specialised training and clinical supervision to support their work.

The teams understood and adhered to the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA).

Our findings

Assessment of needs and planning of care

Each patient had a comprehensive assessment completed as part of the admission process which included the patient's social, occupational, cultural, physical and psychological needs and preferences. Specific evidenced based assessment tools were used by members of the multi-disciplinary team (MDT) to gain more detailed information if clinically indicated.

All patients were registered with their own General Practitioner (GP). If patients were unable to visit their own GP for clinical reasons, they were able to access a GP who provided a drop in service on the wards. Each patient had an annual health check completed.

The teams used 'My shared pathway' with patients from admission. This is a recognised outcome measure used in secure care which utilises booklets of questions that staff and patients use to assess and monitor the patient's progress in a number of important areas. These include awareness of the events leading to their admission into secure care, health, relationships, safety and risks. It also details the patient's future wishes, advanced statements and preferences they may have about their care and treatment. Discharge was planned from the point of admission which is in line with best practice guidance.

All the care records we looked at included a comprehensive risk assessment and relapse prevention plan for each patient. This included the patient's risks to self, others and from others due their vulnerability.

The plans provided specific details of interventions which needed to be put in place if the patient's mental health deteriorated to prevent a relapse of their illness. A care plan was developed with the patient to meet their identified needs under the framework of the Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing a patient's mental health care and treatment needs. The care plans we looked at were centred on the needs of the patient and were recovery orientated. Patients were fully involved in developing and reviewing their care plans with staff.

Are services effective?

Outstanding ☆

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.

Patients' carers and advocates were involved as appropriate and according to the patient's wishes. Staff proactively engaged with carers to identify their needs and assisted them to access any support they may need.

Best practice in treatment and care

The wards provided care and treatment which was underpinned by the principles of the recovery model. There were many examples of how the wards had integrated best practice within the care and treatment they provided to patients.

The teams used 'My Shared Pathway' with patients from admission. This is a recognised outcome measure used in secure care and is in line with best practice. Staff also used psycho social interventions (PSI) in addition to medication to treat patients' diagnosed with psychosis as recommended by the National Institute for Health and Clinical Excellence (NICE). One patient told us, "I see the psychologist. I do the stress vulnerability model. I've learnt how to deal with stress now. They are doing all they can to get me well. They gave me some new medication and it really works."

Some staff had trained in PSI at university and each ward had an identified PSI lead. In addition, staff received clinical supervision from a psychologist in line with best practice. The wards accessed a specialist team of clinicians trained in family therapy interventions for patients and their carers who were assessed as suitable for this therapy.

Discharge was planned from the point of admission which is in line with best practice guidance.

Staff took all practical steps to involve patients in developing and reviewing their own care plans. Patients were provided with a copy of these. Each patient received 25 hours of activity each week which was meaningful to them. Staff made great efforts to ensure that activities were based upon patients' recovery needs, strengths and wishes where possible. Activities focussed on developing patients' educational, social and psychological needs. Examples of this included one patient who did voluntary work for a local charity whilst on leave and another patient who had completed GCSE maths with the help of a maths tutor who visited them on the ward on a weekly basis.

On the rehabilitation unit, there were robust step down procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

Both wards were members of the Royal College of Psychiatrists Forensic Quality Network for Mental Health Services. The Quality Network reviews services against criteria which have been developed from the Department of Health's Best Practice Guidance: Specification for adult medium-secure services, 2007, and Low Secure Services: Good practice commissioning guide 2012. The wards were peer reviewed by the network in January 2014 which commended the teams for many areas of good practice. The network scored the teams at 100% in four areas and at 77% overall. Since the review, the teams had made improvements as recommended by the network.

Skilled staff to deliver care

We spoke with a range of staff across the two wards including the service manager, ward manager, deputy ward managers, registered nursing and health care support staff, occupational therapists, medical staff and a psychologist. Staff told us they were fully supported by the service to access training to assist them within their role. This included both compulsory training and more specialist training such as training in psycho social interventions, family therapy and risk assessment.

The teams had achieved 100% compliance with the trusts' compulsory training and 100% compliance with staff appraisals.

Staff told us they received regular individual or group clinical supervision and we saw evidence which confirmed this.

Multi-disciplinary and inter-agency team work

All the staff we spoke with told us that they were supported by a range of professionals within the multi-disciplinary team (MDT) framework to provide care and treatment to patients. This included ward based professionals such as psychologists, occupational therapists, occupational therapy assistants, consultant psychiatrist and ward doctors, nursing and medical staff and health care support workers. In addition; the wards were supported by social workers, dentists, pharmacists, independent mental health advocates, faith leaders, general practitioners, dieticians and care co-ordinators for example. We saw evidence that

Are services effective?

Outstanding ☆

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.

MDT and care programme approach (CPA) meetings had input from the patient and professionals involved in the patient's care including their care co-ordinator. Decisions were made using the MDT approach. Carers or relatives were also involved in line with the patient's wishes.

We attended a MDT meeting on the assessment ward which was attended by a wide range of professionals. Each professional who worked with the patient had completed a weekly summary of the patient's progress over the previous week which was projected onto a screen for all present to read. The summaries included specific agenda items from the professionals and patients perspective and any questions or queries the patient wished to discuss. The MDT collectively reviewed the patients progress based on the summaries presented and used this information to develop a formulation. From our observations, there was clear professional respect between the members of the team which was evident through the constructive discussions and confidence to challenge each other that we witnessed throughout the meeting. The patient attended the meeting following the MDT discussion. We observed that they were fully involved in discussions about their care and plans. Any queries they had were addressed and answered fully. Patients care records were up-dated on the screen at the end of the meeting. This meant that attendees were able to see and verify that the records reflected the meeting in 'real time'.

Following each CPA meeting, patients' were shown a copy of the draft CPA documentation and were given the opportunity to add their views before it was finalised. We saw evidence in patients' care records which confirmed this.

Patients we spoke with expressed a level of trust and respect for the staff caring for them which was exceptional and clearly based upon the relationship they had developed with them. For example, one patient told us, "I've got my MDT today. We are going to discuss my leave because it was stopped. I know why. I am sure I will get it back today though because I have done everything I needed to so they will give me it back like they said they would today."

Adherence to the MHA and the MHA Code of Practice

Mental Health Act (MHA) documentation was present and available for inspection and was in order. Approved mental health practitioner (AMHP) reports were present with the MHA documents as were letters from the Secretary of State authorising leave where appropriate, for restricted patients. Section renewals had been made in good time.

Patients were aware of their rights under the MHA 1983 and there was evidence that these were repeated at regular intervals. There was documentation relating to patients' understanding of their rights and these were repeated more frequently if the patient had not understood them previously. This process was monitored on the summary board in the nursing office and was reviewed in MDT meetings. Independent mental health advocate (IMHA) services were routinely offered and were provided through Sheffield mental health advocacy services.

We found evidence that patients' capacity to consent or dissent to treatment was assessed and documented in line with the Code of Practice Mental Health Act 1983 (CoP). On the sample of patients' prescription charts we looked at, there were no discrepancies between medications being administered and medication listed on the the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms.

We found that there was a standardised process in place for authorising leave under section 17 of the MHA. Copies of leave forms had been given to patients and others as per the MHA CoP in the majority of cases. There were specified conditions identified and "unescorted" and "escorted" leave forms had been completed accordingly, with the exception of one. Risk assessments had been completed prior to leave being taken and were recorded in patients' notes. There was also evidence of a review of leave afterwards detailed in patients' care records.

It was not clear from speaking with staff and reviewing one patient's care record, whether they had received the letter from the Ministry of Justice explaining the roles of hospital managers and the responsible clinician since their transfer to Forest Lodge. We were assured by staff this would be addressed.

Good practice in applying the MCA

All of the patients on both wards were detained under the Mental Health Act 1983 (MHA) and treatment decisions for mental disorder were made under the legal framework of

Are services effective?

Outstanding ☆

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.

the MHA. Staff understood the limitations of the MHA, for example that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues.

Staff had received training in the Mental Capacity Act (MCA). They understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

Staff took all practical steps to involve patients and their carers or advocates in decisions regarding their care and treatment.

Outstanding ☆

Are services caring?

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

Summary of findings

We have judged the service as outstanding in this area. This was because despite being detained under the Mental Health Act (MHA), there was a culture of empowerment and trust between patients, carers and staff.

All the patients we spoke with told us that staff treated them well and they were making good progress on the ward they were staying. They all spoke very positively about the attitude of the staff caring for them and felt fully informed and involved in decisions about their care and treatment. They were able to discuss their care plans with us and plans for their future.

Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act.

We found several examples which demonstrated that staff took every opportunity possible to involve patients and their carers in the care and treatment they received from admission to discharge. This included developing and reviewing plans of care with their named nurse to attendance at MDT/CPA meetings.

The teams actively supported patients and their relatives to keep in contact with technology such as video conferencing, allowing patients to have their own mobile phones where this was safe to do so and supporting visits from relatives. The service also provided support to patients' relatives and carers within an established relatives support group.

The service had set up joint training for patients and staff to attend on risk assessments to promote learning. The wards held fortnightly community meetings which all patients were encouraged to attend.

Our findings

Kindness, dignity, respect and support

Throughout our visit to the wards, we saw staff interacting positively and proactively with patients. Patients appeared relaxed and comfortable in the presence of staff. One member of staff told us, "We don't focus on the offence people have committed; we focus on the person and their life."

Despite being detained under the MHA, all the patients we spoke with told us that staff treated them well and they were making good progress on the ward they were staying. They all spoke very positively about the attitude of the staff caring for them. One patient told us, "Staff have been brilliant. I can talk to any of them and they give me advice." Another patient said, "The team are doing all they can to help me get out and move on".

We saw that the observation panels in patients' bedroom doors were all in the closed position and only opened for the purpose of observation by staff in line with the trust policy. We observed staff knocking on the doors of bedrooms before entering. This demonstrated that patients' privacy and dignity was being maintained by staff.

On the rehabilitation ward, patients were given a key to their bedroom so they could lock their own door.

The involvement of people in the care they receive

Patients were provided with a range of information about the service on admission and allocated a qualified named nurse. We found several examples which demonstrated that staff took every opportunity to involve patients and their carers in the care and treatment they received from admission to discharge. This included developing and reviewing plans of care with their named nurse to attendance at MDT/CPA meetings. During the multi-disciplinary team meeting we attended, we observed how staff proactively involved the patient in their care. The patient was treated with respect by staff and encouraged to express any views they had about their progress, care or treatment within the meeting.

Patients had regular access to advocacy including specialist independent mental health advocacy (IMHA) for patients detained under the Mental Health Act. Staff informed patients about the availability of the IMHAs to help them access the service and enable them to understand what assistance the IMHA could provide.

The teams actively promoted contact between patients, their families and friends. This had included the service funding the travel expenses of a relative, under exceptional circumstances, to enable them to visit a patient on the

Are services caring?

Outstanding ☆

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

ward. Patients also had access to the internet so they could remain in contact with their friends and family through SKYPE. In addition, patients were allowed to have personal mobile smart phones following the completion of a satisfactory risk assessment.

The service held regular relative support groups for carers and patients relatives.

The service had set up training for patients and staff to attend on risk assessments to promote joint learning.

The wards held fortnightly community meetings which all patients were encouraged to attend. Staff told us they were held at lunchtimes to maximise attendance and the participation of patients. Patients told us they felt listened to by staff and confirmed that staff responded to feedback or ideas they shared in the community meetings.

Good

Are services responsive to people's needs?

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

Summary of findings

We have judged the service as good in this area because the wards proactively promoted patients' recovery from admission to discharge. They achieved this by ensuring each patient had access to the facilities and therapies they needed to assist them in the current stage of their recovery. The wards shared a philosophy of care focussed upon the principles of the recovery model. Staff took all practical steps to minimise restrictions on patients where possible, despite the low secure requirements of the service and legal restrictions imposed on patients.

Ward staff were sensitive and respectful in providing care and treatment which met patient's cultural, social, physical, psychological and spiritual needs. They offered an excellent range of recreational and therapeutic activities and facilities to support patient's recovery which were available seven days a week including evenings. This was also enhanced by external support links the wards had developed with local faith leaders, specialist advocates, Sheffield College and the Open University.

Discharge was planned from point of admission and reviewed regularly through patients' multi-disciplinary team (MDT) and care programme approach (CPA) meetings.

Despite the difficulties the service faced securing suitable accommodation for some patients due to their complex needs' and past offending behaviour; every patient had a discharge plan in place.

The average length of stay on the wards was 18 months which is lower than average when compared to similar services. The lack of re-admissions post discharge from the wards provided evidence to show that the discharge process was effective and patients received the support they needed.

The wards had a 'fast track' complaints system in place which enabled patients or visitors to raise an informal complaint if they did not wish to make a formal complaint. Patients were given information and support about how they could raise a formal complaint or provide feedback through the patient advice liaison service (PALS), advocacy or directly to the trust.

Our findings

Access, discharge and bed management

Admissions to the wards were managed by the NHS England specialist commissioning team. The consultant psychiatrist was involved in reviewing referrals to the wards with members of the multi-disciplinary team and commissioners. This was to ensure the patients' needs could be safely met on the wards and that the level of security was consistent with the level of risk the patient posed. Referrals were accepted from a variety of sources, including the courts, prison and other NHS or independent healthcare providers.

Discharge was planned from point of admission and reviewed regularly through patients' MDT and care programme approach (CPA) meetings. Each patient had an allocated care co-ordinator who attended their CPA meetings. The average length of stay on the wards was 18 months which is lower than average when compared to similar services. The bed occupancy for the assessment ward was 80% over the past six months. This meant there was not a waiting list for referrals to the ward.

The bed occupancy for the rehabilitation ward was 96% over the past six months. Research indicates that bed occupancy levels over 85% can have a negative impact on care delivery. The service manager told us that this figure was due to the ward having three delayed discharges in the six months prior to our visit. The delayed discharges were due to suitable accommodation in the community not been available when these patients were ready for discharge. Staff told us that it could be difficult securing suitable accommodation for some patients due to their complex needs' and past offending behaviour. Despite this, we spoke with several patients who told us they were working towards discharge with staff and all patients had a comprehensive discharge plan in place. One patient we spoke with told us they had been to view a flat that morning and another said they were working towards being discharged by Spring 2015. Staff explained the discharge process for patients was gradual with planned leave to help ease the transition from hospital into the community and reduce the risk of relapse. This was reflected in information the trust provided which showed the service had no re-admissions within 90 days of discharge this year. All patients received follow up aftercare under the CPA process.

Good

Are services responsive to people's needs?

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

The ward environment optimises recovery, comfort and dignity

The wards were calm and relaxed throughout our visit. All areas were in good decorative order and well maintained. There were a range of excellent recreational and therapeutic activities and facilities to support patient's recovery. These included therapy rooms, assessment kitchens, quiet rooms and main TV lounge areas. There was a large shared recreational area which had a pool table, games console and board games provided. Patients also had access to a fully equipped gym, laundry room and a large activity room. Activities were on offer seven days a week including evenings.

The wards had rooms where patients could take their family and visitors for privacy including a child visiting room which was located off the main ward areas. The wards had access to suitable outside space.

On the rehabilitation ward, there was a kitchen for patients' use, with individual locker space for patients' cooking ingredients. Patients had access to tea and coffee-making facilities at all times and free access to their own bedrooms during the day. Patients were able to personalise their bedrooms.

The wards had internet access for patients use and pay phones on each ward although the phone on the assessment ward was not working properly on the day of our visit as it only accepted in-coming calls. The ward manager told us this had been reported to be fixed. The pay phone on the rehabilitation ward was on the main corridor. It did not have a hood which meant that conversations could be overhead. Private calls to advocacy or legal services were facilitated using the ward 'phone. The ward manager told us they would look into resolving this.

Patients told us they were happy with the quality of the food provision on the wards.

Ward policies and procedures minimise restrictions

The wards shared a philosophy of care focused upon the principles of the recovery model. Staff took all practical steps to minimise restrictions on patients where possible, despite the low secure requirements of the service and legal restrictions imposed on patients. This was achieved through staff completing environmental and individual patient risk assessments and the use of appropriate staffing levels.

On the rehabilitation ward, patients had a key to their rooms so they could lock their doors when they wished. Restricted items, such as razors, were kept in the main office but there was no lockable storage patients could use for personal items, such as documentation.

The wards had recently implemented a pilot no smoking ban within the grounds. This had been agreed with input from patients and advocacy. Patients were only allowed to smoke off site whilst they were on leave. Patients had access to smoking cessation services to assist them to stop smoking. We were not made aware of any concerns patients had regarding this restriction during our visit to the wards.

There were no zonal restrictions within the wards.

Meeting the needs of all people who use the service

The wards were fully compliant with the requirements of the Disability Discrimination Act.

Patients had access to advocacy including independent mental health advocates (IMHA) for patients detained under the Mental Health Act as required by the Code of Practice. The service could also access advocates from different backgrounds such as Caribbean advocates through local Citizens' Advice Bureau. Information was available on advocacy services for patients to access help and support.

Staff could access interpreters for patients and their carers through the trust. A range of leaflets were available in different languages and formats such as large print, to enable patients and their relatives to understand what care and treatment could be provided. These included health promotion, medication and information about the service.

Patients were able to access Maths and English classes once a week from a teacher who visited the service. The service had also developed good links with Sheffield College and the Open University.

The service had a multi faith room which patients could use to practice their faith. They also had good access to faith leaders who could attend the wards.

Patients were offered a choice of meals which respected their cultural needs or preferences.

Listening to and learning from concerns and complaints

Good

Are services responsive to people's needs?

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

There were leaflets on the wards which provided information about how patients and visitors could make a complaint or raise a concern they may have on the ward. The wards had access to the patient advice and liaison service (PALS) which offered support to patients who wished to raise a concern, complaint or compliment regarding the ward they were on. Patients had access to advocacy.

The complaints process was included in the information leaflet for patients, visitors and carers. Forest Lodge had received two formal complaints in the past 12 months, both of which had been fully investigated within the set time-scale as per trust policy. They were both upheld.

The wards had a 'fast track' complaints system in place which enabled patients or visitors to raise an informal complaint if they did not wish to make a formal complaint. This system meant that patients or visitors could receive a response to their complaint much quicker than a complaint made through the formal trust process. Forest Lodge had received one fast track complaint in the previous 12 months which was responded to within the time-scale.

The wards held fortnightly community meetings with patients. Patients we spoke with confirmed they felt able to raise any issues informally within these meetings. They told us they felt listened to by staff.

Complaints and concerns were discussed at ward meetings as a set agenda item.

Are services well-led?

Outstanding ☆

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

Summary of findings

We have rated this service as outstanding in this area because the wards provided care and treatment which was underpinned by the principles of the recovery model which was in line with the trust vision and values. Staff were committed, highly motivated and proud of their work and the teams they worked within.

The wards had strong local governance arrangements in place to monitor the quality of service delivery through a range of internal and external audits. These included risks, incidents, complaints, compliments, infection control, medication, Mental Health Act monitoring and security issues.

The wards proactively sought feedback from patients to improve the service.

Staff participated in a number of forums focused on improving practice which included staff meetings, group supervision, away days and governance meetings.

Staff told us the senior managers on the ward were visible, approachable and had an 'open door' policy. Managers ensured that compliance with mandatory training, appraisals and supervision was maintained by all staff members.

Both wards were members of the Royal College of Psychiatrists Forensic Quality Network for Mental Health Services. The quality network reviews services against criteria which have been developed from the Department of Health's Best Practice Guidance. The wards were peer reviewed by the network in January 2014 and have implemented all the recommendations made by the network since. This demonstrated the wards were open to external scrutiny and responsive in making positive changes to the service based on feedback received.

Our findings

Vision and values

The wards provided care and treatment which was underpinned by the principles of the recovery model. This was in line with the trust vision and values. Staff we spoke with were clear about the vision and direction of the ward they worked on and the service as a whole. There was a clear distinction between the remit of each ward which staff were able to explain to us. The wards were managed by the same ward manager and service manager which helped to promote continuity and a shared vision within the teams.

It was apparent through our observations, review of care records and from speaking with staff and patients that the teams focused on meeting the holistic needs' of the patients and did not define patients purely based on their risks or past offending behaviours.

Staff told us that senior managers and executives from the trust visited the wards regularly.

Good governance

The wards had strong local governance arrangements in place to monitor the quality of service delivery. The forensic wards held regular staff meetings that had an agenda which was focused on governance issues such as risks, complaints, incidents and audit outcomes. Structured governance review meetings took place every three months. The teams also held team 'away days' four times a year to reflect on their progress and discuss and plan ways to improve the service in the future.

There were a number of internally generated audits completed on a regular basis which included care records, Mental Health Act documentation, infection control, medication, ligature and environmental security audits. In addition the wards also provided quarterly quality reports to the commissioners of the service and the trust. Monthly incident reports were also submitted to NHS England. This meant the service was open to external scrutiny regarding quality and safety issues.

The senior manager escalated any immediate concerns through the operational manager. However; they told us they had recently been invited to attend the directorate wide senior management team meetings. They said this was a positive move forward which would enable them to directly contribute and feel part of the directorate wide team. This also meant that locally identified governance issues could be directly linked into the directorate governance meetings through the senior manager which provided assurance that issues could be escalated and shared across services.

Are services well-led?

Outstanding ☆

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.

The teams had an effective system in place which flagged when mandatory training was due to expire. Managers proactively managed this to ensure that compliance with mandatory training, appraisals and supervision was maintained by all staff members.

Leadership, morale and staff engagement

Without exception, we found all staff we spoke with to be committed, highly motivated and proud of their work and the teams they worked within. Staff felt supported by the management team and their colleagues within the wards.

Staff told us they felt confident raising any concerns or idea's to improve the service they may have with their manager and were confident they would be listened to. There were a number of ways staff told us they share their views which included staff meetings, group supervision, away days and governance meetings. Staff told us the senior managers on the ward were visible, approachable and had an 'open door' policy. They told us the manager and teams were open to trying new ways of working to improve the service they provided.

Staff sickness and absence rates were within expected boundaries when compared to similar services.

Commitment to quality improvement and innovation

The wards had a range of established and embedded processes in place to monitor the quality and safety of the service they provided. These included regular internally generated audits, team meetings and away days, patient feedback through the patient liaison and advice service (PALS), friends and family test and patient questionnaires. The wards were also required to submit quality reports to NHS England and commissioners. They had achieved the latest Commissioning for Quality and Innovation (CQUIN) targets set by commissioners. CQUIN targets are used to support improvements in the quality of services.

Both wards were members of the Royal College of Psychiatrists Forensic Quality Network for Mental Health Services. The quality network reviews services against criteria which have been developed from the Department of Health's Best Practice Guidance: Specification for adult medium-secure services, 2007, and Low Secure Services: Good practice commissioning guide 2012. The wards were reviewed by the network in January 2014. Overall, they met 77% of Low Secure Standards. The service met 100% of standards in four areas: physical health care, discharge, workforce and governance. Since the review, the teams have addressed the recommendations made by the network to further improve the service. As a result of this information we concluded the trust was open to external scrutiny as a means of improving practice and the treatment and care of people that used the service.

The wards gave patients a satisfaction exit survey when they were being discharged. The survey covered all aspects of the care and treatment provided such as dietary requirements, respect and dignity, access to activities, involvement in care planning, medication and the attitude of staff. Overall, we saw that the results of the survey results for the past year were very positive. One issue was raised through the survey that patients would like more support in the multi-disciplinary meetings (MDT) meetings with asking about medication although patients also reported they understood and were given information about their medication generally. The manager told us they had developed a specific questionnaire to gain more information about the issues patients wanted more support with so they could address this issue. These questionnaires were currently been handed out through patients named nurses. This demonstrates that the service proactively acts on feedback from patients to improve the service provided.