The Langford Centre

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?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

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 gave an overall rating for the service of **requires improvement** because:

- Patients' privacy, dignity and safety were compromised on Daffodil ward because of a failure by staff to adequately assess risk when male patients were attending activities on the female ward.
- We observed poor infection control in the laundry room on Pevensey ward. Staff completed daily ward environmental checks but it was not clear of the effectiveness of them.
- The clinic rooms on the wards were small and patients' weight and physical health observations were completed in the lounge, which compromised their privacy and dignity.
- There was no recording of mandatory training for 'bank' and agency staff. Permanent staff were not aware of which agency staff could or could not assist with restraining patients if required.
- The service imposed blanket restrictions on its patients. All patients were restricted because of the actions of individual patients.
- We found little evidence of planning for discharge incorporated into patients' assessments.

However:

- The culture of the service was open and transparent with a drive for continual improvement. There was a person-centred culture. We saw evidence of patient involvement in care planning. Patients had a comprehensive assessment in place that was individualised and person-centred with a focus on patient goals and recovery.
- Patients had access to innovative psychological therapies as part of their treatment. The service had a robust multidisciplinary team who worked well together and were fully involved in patients' care.
- Patients experienced care and treatment that was compassionate, sensitive and person-centred. Staff morale was generally high and the wards supported each other. Wards were well-led and there was clear leadership at a local level. The ward managers were visible on the wards during the day and the multidisciplinary team were available to support patients and staff.
- There was a good provision of and access to therapeutic activities and strong links with external organisations.

Summary of findings

Contents

Requires improvement

The Langford Centre

Services we looked at
Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Wards for people with learning disabilities or autism.

We inspected this service as a location and not as a core service. The service provides both low secure and rehabilitation services to male and female adults with a range of mental health needs, learning disabilities and substance misuse.

Summary of this inspection

Background to The Langford Centre

The Langford Centre is provided by The Langford Clinic Limited, now Bramley Health Care.

The service provides both low secure and rehabilitation services to male and female adults with a range of mental health needs, learning disabilities and substance misuse. It has 74 beds over six wards. On the days of the inspection there were 23 patients accommodated over four wards. Two wards had been closed.

Daffodil ward is a 15 bed female locked rehabilitation ward for patients with complex needs. Pevensey ward is a 15 bed male low secure ward. Highwoods ward is a nine bed male locked rehabilitation ward. Blenheim ward is a 10 bed male learning disability locked ward. Balmoral and Camber ward were closed at the time of the inspection. The provider informed us that they planned to close Highwoods ward within six weeks of the inspection visit.

We have inspected The Langford Centre six times since registration with the Care Quality Commission (CQC) in 2011. The last inspection took place on the 6 August 2014.

Our inspection team

Team leader: Michelle McLeavey, inspection manager

The team that inspected the service comprised six people; a CQC inspection manager, two CQC inspectors, a clinical psychologist, a Mental Health Act reviewer and an expert by experience.

Why we carried out this inspection

We inspected this service as part of our on going comprehensive mental health inspection programme. We found the service to be non-compliant at its previous inspection on the 6 August 2014, so we reviewed these areas as part of this inspection.

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 service, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited all four wards of the hospital and looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 10 patients who were using the service;
- collected feedback from nine patients using comment cards;

Summary of this inspection

- received feedback from four relatives;
- looked at 22 treatment records of patients;
- spoke with the hospital director who was also the registered manager of the service;
- spoke with 21 staff working in the service, including senior managers, ward managers, doctors, nurses, therapeutic care workers, social worker, psychologist, assistant psychologist, and occupational therapist;
- attended and observed two hand-over meetings, two multidisciplinary meetings, one therapy session and one ward round;
- carried out a mental health act monitoring visit on Pevensey ward;
- received feedback about the service from six care coordinators or commissioners;
- received information from one independent advocate;
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 10 patients across the four wards. We also received completed comment cards from nine patients. Most patients told us they found staff to be passionate, caring and supportive. They were generally positive about their experience in the hospital and felt that they received support that was appropriate to their needs. Patients on Blenheim ward, Pevensey ward and Highwoods ward spoke of feeling safe on the wards. Patients on Daffodil ward told us they did not always feel safe or comfortable when male patients were on the ward. Patients felt that most staff had an understanding of their care needs and were actively involved in their care planning. They told us that they found the ward environment required redecoration.

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:

- Patients' privacy, dignity and safety on Daffodil and Pevensey wards were compromised because of a failure by staff to adequately assess risk. On Daffodil and Blenheim wards, patients did not have privacy when they received treatment or physical health monitoring.
- On Pevensey ward, we observed poor infection control. Staff did not wash mop heads on a sluice wash and they were stored next to clean towels and bedding.
- It was not clear from the training matrix what training 'Bank' staff had completed. There was no record of agency staff having completed de-escalation and physical intervention techniques.
- Staff did not know which agency staff could assist with restraining patients if required.
- Restrictive practices and blanket restrictions were in place for all patients.

However:

- Staff had completed ligature risk assessments for all wards and identified what action to take to mitigate the risks identified.
- Patients had an allocated care team and were offered one to one meetings with staff regularly.
- Patients risk information was reviewed regularly by staff and recorded.
- There were appropriate systems embedded with regards to safeguarding adults at risk and children.

Are services effective?

Good

We rated effective as **good** because:

- Patients had a comprehensive assessment in place that was individualised, person-centred and holistic with a focus on recovery.
- Patients had access to a good variety of psychological therapies as part of their treatment.
- The service had a robust multidisciplinary team who worked well together and were fully involved in patient's care.
- Psychologists and occupational therapists were an active part of the multidisciplinary team.
- There was effective inter-agency working and on going monitoring of physical healthcare conditions was taking place.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- The culture on the wards was person-centred.
- Staff involved patients in the planning of their care. Care plans were person-centred and recovery orientated.
- The ten patients that we spoke with were generally positive about their care. They told us that they found the staff to be passionate, caring and supportive.
- Staff understood patients' needs and involved patients in their care.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- We found little evidence of planning for discharge incorporated into patients' assessments.
- We received mixed feedback about the food provision.
- There was a lack of privacy for patients making telephone calls on the wards.

However:

- There was good provision of and access to therapeutic activities.
- The wards were aware of the diverse needs of the patients and provided support when appropriate.
- Staff received training in equality and diversity as part of their mandatory training.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff told us they felt well supported by the service and the organisation.
- There was good leadership at local level.
- The ward managers and members of the multidisciplinary team were visible on the wards and accessible to staff and patients.
- Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could.

Detailed findings from this inspection

Mental Health Act responsibilities

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

We found that the use of the Mental Health Act (MHA) 1983 was good in the services. Mental health documentation reviewed was found to be compliant with the MHA and its Code of Practice.

There were copies of consent to treatment forms accompanying the medication charts. Patients had their rights under the MHA explained to them routinely. Patients had access to an independent mental health advocate who could support them.

Training records showed that 75% of staff had received mandatory training in the use of the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.

Training records showed that 92% of staff had received mandatory training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Their understanding of the legislation and how it affected everyday clinical practice was good.

Where patients were not detained under the Mental Health Act their capacity to consent to medication and to stay in the hospital as an informal patient had been assessed and documented.

One DoLS application had been made on Daffodil ward within the last six months.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- The wards' layout enabled staff to observe most parts of the wards. There were some restricted lines of sight across all four wards but these were adequately mitigated.
- The wards were generally clean and clutter free. We noted the kitchens on Pevensey and Daffodil wards had broken and or missing cupboard doors. Some refurbishment works were taking place at the time of the inspection. We observed that the activity room on Daffodil ward was in need of redecoration as was the ward areas on Pevensey ward, Blenheim ward and Highwoods ward. There was a planned works for refurbishment across the service
- All four wards were gender specific. Pevensey ward, Highwoods ward and Blenheim ward accommodated male patients. Daffodil ward accommodated female patients.
- On the day of the inspection, we observed male patients engaging in therapeutic art activities in the dining room on Daffodil ward. No female patients were seen to be engaging in the activity. We spoke with staff and patients who told us that weekly therapeutic activities such as art and yoga took place on Daffodil ward and male patients from the other wards would attend. Numeracy took place weekly on Pevensey ward and female patients from Daffodil ward attended. We reviewed care records and found that staff had not completed risk assessments about patients of the opposite sex going onto single sex wards for the activities.
- Patient's privacy, dignity and safety were compromised because of failure by staff to adequately assess the risk. Upon entering the wards, opposite sex patients had to pass female/male only bedrooms, many of which had the doors open and patients inside their rooms. On Daffodil ward, vulnerable female patients were observed walking around the ward with minimal clothing on. Patients on Daffodil ward told us they did not always feel comfortable or safe when male patients were on the ward. We observed male patients using the female only communal toilets and bathrooms. Staff told us they believed the reason for the mixed sex integration was to support patients' recovery. However, we were unable to find any evidence in the patient's clinical notes to support this.
- The clinic rooms on each of the wards were small. On Blenheim ward the blood pressure (BP) monitor and scales were stored in the ward office due to lack of space in the clinic room. On Daffodil and Blenheim wards patients' physical health observations and weight checks were completed in the ward lounge due to lack of space in the clinic room. This affected people's privacy when having these checks carried out.
- Emergency medications were all in date. Resuscitation equipment was in good working order, readily available and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. 95% of staff had undertaken training in life support techniques.

Requires improvement

Forensic inpatient/secure wards

- There were appropriate processes in place for the management of clinical waste across the service and staff were able to discuss these with us. We saw that staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins and these were labelled correctly and not over-filled.
- We saw that all wards had ligature risk assessments and where the ligature points could not be removed there was detailed specific action to be taken to mitigate the risks identified.
- Environmental risk assessments and ward audits were carried out. Each ward carried out twice-daily environmental checks. It was not clear of the effectiveness of the environmental checks. This was because forms we viewed stated that areas had been checked and was safe and free from need of repair. However, on a tour of Daffodil ward several lights were not working in the corridors, activity/art room and the de-escalation room. There was a problem with staff keys not being able to access certain doors on the ward. We raised this as a concern with ward staff and noted that immediate action was taken to resolve the issues.
- There were records to demonstrate that all wards participated in monthly health and safety meetings. .
- We observed poor infection control in the laundry room on Pevensey ward. Wet mop heads were stored next to clean towels and bedding. It was not possible to see which mop heads were clean or dirty. We observed mop heads being washed at 40 degrees and not the required 75 degrees sluice wash. The service did not use disposable mop heads.
- All staff carried a personal alarm on them at all times. Alarms alerted all staff in the hospital to an emergency situation. We observed staff responding appropriately and promptly to alarm calls.

Safe staffing

- The total number of whole time equivalent (WTE) substantive staff for the hospital was 102 (as at 1 April 2015). The total number of staff leaving in the previous twelve months was 44 WTE. The staff turnover in that time period was 43%.
- Staff vacancy rates were 8% at the beginning of April 2015. There were five vacancies for qualified nurses and four vacancies for nursing assistants across the service. The registered manager told us that the service was actively recruiting to fill the vacancies.
- We noted that the overall staff sickness absence level for the period ending 1 April 2015 was 3%.
- We looked at staffing rotas for the weeks prior to and for the week of the inspection and these showed that staffing levels were in line with the levels and skill mix determined by the service as safe. However, some patients told us that Section 17 escorted leave into the community was at times cancelled due to lack of staffing. We observed on the day of the inspection delays with patients' utilising their Section17 leave on Daffodil ward. Staff and patients told us that due to staff pressures at times there were delays with accessing the ward garden areas for fresh air and smoking. Patients required staff support to access the ward gardens as all doors were operated by fob, which only the staff had access too. The service did not put in place alternative arrangements to support any patient with being able to access ward gardens independently.
- The ward managers and staff confirmed they were able to increase staffing levels when additional support was required so patients could attend appointments and ensure their leave took place. However, as this was coordinated by the ward nurse it often meant that they were tied up in administrative work, which took them away from the clinical environment.
- Figures provided by the service for the period 02 February 2015 to 26 April 2015 showed that 792 shifts were filled by 'bank' or agency staff to cover sickness, absence or vacancies. There were no occasions when 'bank' or agency staff could not be obtained to cover shifts.
- We reviewed the personnel files of five staff working in the service. These showed that checks were carried out on staff prior to them commencing employment with the service. These included checks with the Disclosure and Barring Service (DBS), referencing, prospective employees' qualifications and professional registration and interview record notes.

Requires improvement

Forensic inpatient/secure wards

- Most patients told us that they were offered regular one-to-one meetings with staff. All patients had an allocated care team including primary nurse; associate nurse and therapeutic care worker.
- Medical staff told us that there were adequate doctors available over a 24-hour period, seven days each week who were available to respond quickly on the ward in an emergency. This was partly outsourced via a service level agreement with the local trust that provided four external doctors to support on call for The Langford Centre and one other independent service. Twice in the last twelve months, the on-call doctor has had to attend site out of hours.
- Staff received appropriate mandatory training. The majority of permanent staff had completed the training required in 20 different areas. This included training in safeguarding adults at risk, which 96% of staff had completed, and basic life support, which 81% of staff had completed. Other completion rates ranged from 36% for fire safety to 97% for de-escalation and physical intervention techniques.
- 'Bank' staff were expected to complete the same mandatory training as permanent staff. However, it was not clear from the training matrix what training 'bank' staff had actually completed as no dates had been entered onto the matrix.
- Senior managers told us that agency staff were not allowed to assist in restraining patients unless they had completed training with the service for de-escalation and physical intervention techniques. The training matrix did not contain details of any agency staff member having completed this training. Staff told us that they were not aware which agency staff could or could not assist with restraining patients if required.

Assessing and managing risks to patients and staff

- We found that risk formulations were good and structured professional judgement (SPJ) risk assessment tools such as Historical Clinical Risk management – 20 (HCR-20)were used to assess risk factors for violent behaviour.
- All patients received the short term assessment of risk and treatability (START). This meant that a comprehensive and dynamic evaluation of risk was carried out throughout each patient's admission. Risk factors such as self-harm, violence, self-neglect, suicide, victimisation and substance use were assessed.
- We reviewed the risk assessments of 22 patients. Staff completed risk assessments of patients when they were admitted to the wards. Individual risk assessments took into account the patients previous history as well as their current mental state. Patients risk information was reviewed regularly and documented. The reviews of risk were part of the multidisciplinary care review process. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, observation levels of patients might increase or decrease.
- We observed that staff handover meetings and multidisciplinary review meetings included discussion of individual risks to patients.
- We found the same level of restrictive practices across all four wards. All patients used plastic plates and cutlery and were not permitted to use crockery or metal cutlery when eating meals. On Daffodil, Blenheim and Pevensey ward, we observed that patients did not always have free access to hot, cold drinks, and snacks. Snacks were stored in the kitchen as were the facilities to make drinks. Patients needed to request staff assistance when they required a drink or snack. On Daffodil ward art supplies were kept locked in the office and not freely available in the activity room. Staff told us that this was due to misuse by some patients on the ward. Patients were individually assessed for access to mobile phones and internet access. Patients told us they were not allowed to display posters or pictures on their bedroom walls. Some patients had keys to their bedrooms and lockable storage.
- We found that some patients had been individually risk assessed to be able to prepare their own meals and develop skills to support them when discharged back into the community. Both patients on Highwoods ward and four patients on Daffodil ward confirmed with staff that this was the case.
- We found that blanket restrictions across the three wards, such as contraband items, were justified and clear notices were in place for patients explaining why these restrictions were in place. For example, patients

were not permitted to hold cigarette lighters on them whilst on the wards and they were securely stored. Staff told us this was because of the risk of inappropriate use, which could endanger the lives of patients and staff.

- Some patients had access to their bedrooms at any time with the use of a key. Some patients had to request staff assistance, as they did not hold keys themselves. Patients were able to store their possessions securely in their bedrooms in a locked bedside cabinet but they did not have a key to the cabinet. Staff held the keys and patients could request access via a staff member. Staff had not carried out risk assessments to, it was not clear why some patients could have access to bedroom, and bedside cabinet keys and others could not.
- Patients had access to outside space, though most patients were supervised by staff and were not able to access outside areas when they wished. Access to these areas was timed to minimise risk.
- There were appropriate systems embedded with regards to safeguarding adults at risk and children. Safeguarding concerns were reviewed and discussed in handovers and multidisciplinary team (MDT) meetings. Staff had received training in safeguarding vulnerable adults and children and was aware of the services safeguarding policy.
- Staff we spoke with had an understanding of safeguarding issues and their responsibilities in relation to identifying and reporting allegations of abuse. Staff told us of the steps they would take in reporting allegations to the safeguarding lead within the service and felt confident in contacting them for advice when needed.
- We found evidence of good management of medication across Pevensey ward, Blenheim ward and Highwoods ward. For example, we saw that medicines were stored securely on the ward. Temperature records were kept of the medicines fridge and clinic room in which medicines were stored which meant medicines remained fit for use. However, on Daffodil ward we found evidence of missing medications and the reconciliation of controlled drugs. We brought this to the immediate attention of the ward manager and hospital director and an investigation was immediately actioned. Staff were completing audits in relation to the use of controlled drugs but the error identified during the inspection had been missed.
- A pharmacist visited the service weekly to carry out and audit of the medicines system. Staff told us that information from these visits was fed back to the nurses and doctors and any required action was taken promptly. For example, a pharmacy audit carried out on prescription errors found that in July 2014 there were 1.53% of errors compared to March 2015 where there were 0.11% of prescription errors.
- Staff had been trained in the use of physical restraint and understood that these should only be used as a last resort. Guidance published by The Department of Health in April 2014 called 'Positive and Proactive Care' states providers should aim to reduce the use of all restrictive interventions and focus on the use of preventative approaches and de-escalation. We reviewed records and found that de-escalation or positive behaviour support was used proactively. There were 29 incidents of the use of restraint recorded in the six-month period. Of the total incidents, 14 patients had been given rapid tranquilisation while being restrained.
- 'Positive and Proactive Care' included new guidance on the use of face down (prone) restraint, which aimed to ensure that this it is not planned and is only used as a last resort. The guidance accepted that there would be exceptional circumstances when this will happen. Staff told us that prone restraint use was extremely minimal and if used was clearly documented as to the reasons for this. Records we reviewed confirmed that no use of prone restraint was recorded in the six-month period.
- The multidisciplinary team (MDT) reviewed and reflected on incidents of physical restraint daily at the MDT handover meetings and ward handovers.

Track record on safety

- We looked at the record of serious untoward incidents across all wards and found there had been five records in total from 2 February 2015 to 9 March 2015. It is not known from the provider's data which ward they occurred on.

Requires improvement

Forensic inpatient/secure wards

- There were four incidents of patient on staff physical assault and one incident of a patient taking an overdose in the community whilst out on Section 17 leave.

Reporting incidents and learning from when things go wrong

- Staff told us that shared learning across the service took place with regards to serious incidents. Staff were able to give examples where improvements in the quality of service and patient care had been made as a result of learning from incidents.
- Staff we spoke with knew how to recognise and report incidents. Ward managers told us that all incidents were reviewed and discussed among the multidisciplinary team. The system ensured that senior managers within the service were alerted to incidents in a timely manner and could monitor the investigation and response to the incidents.
- Staff were offered debrief after serious incidents in a group setting or individually if required. Reflective practice sessions took place on each ward to enable staff to discuss any incidents that had occurred.
- The service had a Duty of candour policy. Staff we spoke with were familiar with the policy and understood that they had a duty to be open and transparent with patients in relation to their care and treatment and the need to apologise when things go wrong.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans. Records showed that all patients received a physical health assessment and that risks to physical health were identified and managed effectively. Where physical health concerns were identified care plans were put in place to ensure the patient's needs were met and the appropriate clinical observations were carried out. Staff carried out routine physical health monitoring. Each patient was registered with the general practitioner and physical health checks such as ECG's (Electrocardiogram) smear tests, mammograms and well-man checks were routinely carried out when required.
- Care plans were personalised, holistic and recovery oriented. All wards used the care programme approach (CPA) for planning and evaluating care and treatment. The wards had fully implemented "My shared pathway." This is a nationally recognised good practice recovery tool which focuses on a patient's strengths and goals. Health plans were included as part of "My support plan". Blenheim ward had implemented Life Star. Life Star is a holistic recovery tool designed for people with learning disabilities. These were reviewed and updated on a regular basis. Most patients told us that they were encouraged to be fully involved in the planning of their care needs.
- Records were kept in good order and were accessible to staff at all times.

Best practice in treatment and care

- Patients had access to a good variety of psychological therapies recommended by NICE as part of their treatment either on a one to one or group basis. The patient's individualised treatment programme was innovative and tailored to their needs. We saw that specific offence related psychological therapies were available. As of July 2015 85% of patients had psychology assessments and 69% of patients had some form of psychological treatment.
- Occupational therapists used 'The Model of Human Occupational Screening Tool' (MOHOST). The tool is an occupation-focused assessment that shows how far individual and environmental factors help or restrict someone in normal daily life.
- The hospital had a recovery approach to supporting patients. During weekdays there was a wide range of therapeutic activities for individuals and groups on the wards and in the community. For example, once a week patients attended voluntary work at a local animal sanctuary. Yoga sessions and Tai-Chi sessions were facilitated fortnightly and facilitated by an external provider. At the weekend less structured activities were provided by the nursing staff.

- Numeracy and literacy classes were facilitated weekly and provided by tutors who came into the service to improve patient's literacy and numeracy skills.
- Interest checklists were carried out with patients on admission and reviewed and the therapeutic programme of activities on offer was reviewed in April 2015 to ensure patients were engaged in meaningful activity.
- Psychologists and occupational therapist were an active part of the multidisciplinary team.
- Where needed, on going monitoring of physical healthcare conditions was taking place and conditions were well monitored.
- The ward staff were assessing the patients using the Health of the Nation Outcome Scales (HoNOS). These scales covered 12 health and social care domains and enabled the clinicians to build up a picture over time of their patients responses to interventions.
- Staff participated in a range of clinical audits to monitor the effectiveness of services provided including adherence to the CQUIN (Commissioning for quality and innovation) framework. The areas covered included collaborative risk assessments, supporting carer involvement, pre-admission formulations, specialised services quality dashboards and delayed discharges from secure care.
- A physical health audit was undertaken by the medical team in January 2015 and looked at cardio-metabolic risks; risks of venous thromboembolism, and risks associated with high dose antipsychotic treatment.

Skilled staff to deliver care

- The staff working on all of the wards came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training specific to their role.
- All staff we spoke to said they received individual supervision approximately every four to six weeks. Staff told us they valued the supervision they received and felt well supported. Staff also told us that they could speak with managers and peers informally at any time and did not have to wait for formal supervision. Figures provided by the service showed that 100% of staff had received an annual appraisal.
- All doctors employed in the service had undergone professional revalidation.
- The continuous development of staff skills, competence and knowledge was recognised as being integral to ensuring the delivery of high quality care. The psychology department provided additional training such as autism awareness and sexual offending training. Both were developed with patient involvement.
- Staff told us they participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the ward. For example de-briefing meetings took place following an incident on the ward.
- There were regular team meetings and staff told us they felt well supported by their local management structure and colleagues. Ward managers were highly visible and available on the wards and staff morale was high.

Multidisciplinary and inter-agency team work

- A multidisciplinary team meeting (MDT) is composed of members of health and social care professionals. The MDT collaborate together to make treatment recommendations that facilitate quality patient care. Patients we spoke with confirmed they were supported by a number of different professions.
- We observed two MDT meetings and saw that each member of the team contributed and the discussion was effective and focused on sharing information, patient treatment and reviewing the patient's progress and risk management.
- We observed two clinical handover meetings on the wards and found these to be effective and well structured. Staff clearly demonstrated in depth knowledge about the patient group.
- We found evidence of inter-agency working taking place. Care co-ordinators confirmed with us that they were invited to and attended meetings as part of patients' admission and discharge planning. The wards had a link

with a local general practitioner and access to other specialist services. Contact links with local police liaison officers were maintained for the purpose of offending and risk management.

Adherence to the MHA and the MCA Code of Practice

- We reviewed the files of detained patients across the wards and a mental health act reviewer carried out a detailed Mental Health Act (MHA) review on Pevensey ward. MHA documentation was filled in correctly, was up to date and stored appropriately.
- Information of the rights of patients who were detained was displayed clearly on the wards and in an easy to read format.
- Section 132 rights forms were present on all files and rights had been given to patients monthly as per the provider's policy and the MHA Code of Practice. The forms used were comprehensive and explained a number of issues relating to detention under the MHA.
- Staff were aware of the need to explain patients' rights to them under the MHA. We spoke with 10 patients who all confirmed that they had their rights under the MHA routinely read and explained to them.
- Statutory requirements to assess capacity and consent to treatment were being carried out in line with requests for second opinion approved doctors (SOAD) visits. We checked the medication charts for patients who were detained and these had completed consent to treatment forms attached.
- Medication certificates were in place and copies had been attached to the medication charts. Medicine for mental disorder maybe administered to a patient either with his/her capable consent (T2) or, if s/he withholds consent or is incapable of giving consent (T3) authorisation by a second opinion appointed doctor (SOAD). However, it was noted that in some cases these were over twelve months old and new certificates had not been renewed when patients' detentions had been renewed. Best practice would be to renew T2 certificates at twelve monthly intervals for T3 certificates at 24 monthly intervals.
- Staff knew how to contact the MHA office for advice when needed and said that audits were carried out to check the MHA was being applied correctly. Records confirmed that the last audit took place in April 2015.
- Staff had received mandatory training in the use of the MHA. At the time of the inspection, 75% of staff had completed this training. Staff had a good understanding of the MHA and Code of Practice.
- Patients had access to an Independent Mental Health Advocate (IMHA). Independent advocacy services were readily contactable and available to support patients when needed.

Good practice in applying the MCA

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.
- We saw that staff completed Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) training. At the time of the inspection, 92% of staff had completed this training.
- Formal capacity assessments in relation to consent to treatment took place. We found evidence of best interest meetings taking place and these were well documented.
- Where patients were not detained under the Mental Health Act their capacity to consent to medication and to stay in the hospital as an informal patient had been assessed.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- Feedback from all 10 patients we spoke with was generally positive. They told us that they found the staff to be passionate, caring and supportive. Patients felt that most staff had an understanding of their care needs and were actively involved in their care planning.
- External stakeholders told us that communication was generally good and they were provided with regular emails with nursing updates and received up to date reports prior to hospital managers' hearings; mental health review tribunals and care programme approach (CPA) meetings.

Requires improvement

Forensic inpatient/secure wards

- Members of the senior clinical team were easily contactable and responded promptly to emails. On Blenheim ward the use of creative materials and support given by staff to a patient in bereavement was praised.
- Feedback received from families and external stakeholders were mostly good and praised the care and support provided by staff to patients.
- When staff spoke with us about patients, they discussed them in a respectful manner and demonstrated a high level of understanding of their individual needs. Staff appeared interested and engaged in providing high quality care to patients. We observed staff interacted with patients in a positive, caring and compassionate way and they responded promptly to requests for assistance whilst promoting patients dignity.
- Staff had a good understanding of individual needs of patients. This was demonstrated in multidisciplinary team (MDT) meetings and handovers which we observed and in individual discussions with staff. Staff had good knowledge on how to de-escalate situations and worked as a team to promote a safe environment.

The involvement of people in the care they receive

- There was a visible person-centred culture. We saw evidence of patient involvement in records such as 'My shared pathway' and 'Life Star'. We found them to be person-centred and recovery orientated. We reviewed 22 care and treatment records and found that patients had their care plans reviewed regularly with the multidisciplinary care team at ward round and once each month with a member of the ward nursing team. Staff offered patients a copy of their care plan and patients' signed to say that they had been offered. Staff sought patients' views and clearly documented these. For example, patients' wishes and strengths were documented in care plans.
- Details of local advocacy services were displayed on all the wards and patients told us they were supported to access an advocate if they wished.
- We observed staff involving patients in making decisions about their care. Staff sought the patient's agreement throughout. Family and carers were involved when appropriate and information was shared according to the patient's wishes.
- 'You said, we did' boards were displayed on the wards. These contained comments and suggestions from patients and the actions the wards had taken to implement and make changes to improve the quality of the service. For example, on Daffodil ward patients had requested an air conditioning unit for the lounge due to the temperature on the ward and this had been provided by the service.
- Patient experience forums and service user groups took place monthly. Minutes were issued which showed the agenda for what had been discussed and actions taken. A patient's newsletter was developed and issued two monthly, with patients actively encouraged and supported to contribute.
- A 'families and friends' test was introduced in June 2015. This was designed to see if patients would recommend the service to family and friends. Four patients completed the survey of which all were female. The results showed that two patients were extremely likely, one did not know and one was extremely unlikely to recommend the service. This was the first time the provider had carried out the survey and the hospital director told us that they would review this quarterly.
- The wards had regular community meetings for patients to discuss the running of the wards. However, we found that in all wards there was no fixed agenda for the community meeting and copies of the minutes were not readily available for patients to read what had been discussed.
- Across the four wards we found that the majority of patients had advance directives in place which had been signed by the patient and witnessed by another member of staff.
- Patients were involved in developing training programmes for staff, including autism awareness and sexual offending.

Are forensic inpatient/secure wards responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

Requires improvement

Forensic inpatient/secure wards

- The Langford Centre had 74-beds over six wards. At the time of the inspection four wards were open. Camber ward and Balmoral ward were closed. There were a total of 26 vacant beds across the four open wards when we inspected. Bed occupancy ranged from 33% on Daffodil ward to 70% on Pevensey ward.
- There was one delayed discharge reported during the period December 2014 to May 2015. The delay was because a bed could not be found for the patient in the area that the patient wanted. The patient had physical health implications and was awaiting an operation at the general hospital.
- We found little evidence of planning for discharge incorporated into patients' assessments. For example, on Pevensey ward six of the seven patients did not have discharge planning in place.
- Patients were not moved between wards during an admission episode unless they needed to be transferred on clinical grounds and it was deemed to be in the patient's best interests.
- Patients' beds remained open for them to return to following leave from the ward. The average length of stay for patients at the service was 40 months.

The facilities promote recovery, comfort and dignity and confidentiality

- Each of the wards offered access to a secure outside space. However, not all wards had direct access to outside space due to being on upper floor levels.
- All three wards had access to a patient telephone but they were sited in ward corridors and not in a private area. The payphones on the ward did have a privacy hood but patients told us that they still did not feel this was private. Patients we spoke with were not aware of the call tariff for using the payphones and this information was not displayed.
- Patients gave us mixed feedback about the food. Some said they enjoyed the choice offered, others complained about portion sizes and lack of appeal in presentation and taste. We spoke with the kitchen staff who said that they used to meet with patients on the wards to discuss menu options and likes and dislikes of foods. However, this had not happened for some time and staff were unaware as to why this was.
- Most patients spoke highly of the daily and weekly activities that were offered across the four wards. The activities were varied, recovery focused and aimed to motivate patients. We saw that the activities programme included voluntary work, swimming and educational courses included literacy and numeracy skills.
- Occupational therapy was available across all four wards and a variety of therapy sessions were available. We saw they operated a model which focused on a holistic, person centred and recovery based approach. Strong communal links had been established to support patients' transition into the community on discharge.
- The service hosted regular awareness days. Topics included 'cultural diversity day' and 'digni-tea for dignity in action' to explore and celebrate dignity.

Meeting the needs of all people who use the service

- Staff respected patients' diversity and human rights. Attempts were made to meet people's individual needs including cultural, language and religious needs.
- Some staff received training in equality and diversity as part of their mandatory training. We reviewed training records and found that 40% of staff had completed the training.
- Interpreters were available and were used to help assess patients' needs and explain their rights, as well as their care and treatment. Leaflets explaining patients' rights under the MHA were available in different languages.
- A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs to access appropriate meals.

Listening to and learning from concerns and complaints

- Patients were given information about how to make a complaint in the 'patient information pack' they received and information was clearly displayed on the ward noticeboards. Patients we spoke with felt confident that they could raise a complaint but had not needed to do so. Staff were aware of the process for managing complaints
- There had been 20 formal complaints made between May 2014 to April 2015. Five of these were upheld and two were partially upheld.

Requires improvement

Forensic inpatient/secure wards

- The seven complaints that were either upheld or partially upheld related to patients request access to notes, patients complaining about other patients' behaviour and complaints from neighbours about loud noise.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Staff were aware of the organisations vision and values.
- Ward managers had regular contact with the hospital director and senior management team. Staff knew senior managers from the organisation and told us that they had visited the wards.
- Staff told us that they felt well supported by the service and the organisation. Staff said they were well supported by their peers and managers.

Good governance

- Data was collected regularly on performance. We saw that performance was recorded against a range of indicators which included complaints, serious incidents and types of incidents. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance. We saw evidence of improving performance across the four wards.
- Staff used outcome measures such Health of the Nation Outcome Scales (HoNOS) to identify whether people improved following treatment and care.
- Staff participated in a range of clinical audits to monitor the effectiveness of services provided and results were fed back to improve the quality of the service.Audits included adherence to the CQUIN (Commissioning for quality and innovation) framework. The areas covered included collaborative risk assessments, supporting carer involvement, pre-admission formulations, specialised services quality dashboards and delayed discharges from secure care.
- The learning from complaints, serious incidents and patient feedback was identified and actions were planned to improve the service.
- Staff received mandatory training and had regular supervision and appraisals.
- The ward managers told us they were encouraged and supported to manage the wards autonomously. They also said that where they had concerns these could be raised and were appropriately placed on the service's risk register.
- The Mental Health and Learning Disability Data Set (MHLDDS) require all services who have detained patients to submit data on a yearly basis. The Langford Centre submitted data for the period 2013/2014 but failed to do so for 2014/2015.

Leadership, morale and staff engagement

- At the time of our inspection there were no grievance procedures, allegations of bullying or harassment reported across the three wards.
- Staff told us they were aware of the whistle-blowing process and were confident they could raise concerns if needed.
- Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for the patients on the wards. There was high staff morale across the four wards. All the staff we spoke with were enthusiastic and proud with regards to their work and the care they provided for patients on the wards.
- We found the wards to be well-led and there was clear leadership at a local level. The ward managers were visible on the wards during the day and were accessible to staff and patients. Staff described strong leadership across the wards and said that they felt respected and valued.
- The culture of the service was open and transparent with a drive for continual improvement. The service had a Duty of candour policy. Staff that we spoke with were familiar with the policy and informed us that they were aware of their individual responsibilities to be open and transparent in respect of patients care and treatment. They also told us that they felt well supported by the managers to be open and honest.

Commitment to quality improvement and innovation

Requires improvement

Forensic inpatient/secure wards

- The service had established a positive working relationship with two local police liaison officers. The officers were trained in mental health and met regularly with members of staff and patients to review incidents and concerns.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must review where patients' physical health observations and weight checks are carried out.
- The service must review the level of restrictive practice across all of the wards.
- The service must review their processes for recording 'bank' and agency staff mandatory training.
- The service must ensure that it informs all staff of which agency staff can and cannot assist in restraining patients.
- The service must ensure that planning for discharge is incorporated into all patients' assessments.

Action the provider SHOULD take to improve

- The service should review the effectiveness of the daily ward environmental risk assessment checks.
- The service should review patients' access to Section 17 leave.
- The service should ensure that appropriate arrangements for monitoring and auditing the management and use of controlled drugs by the Controlled Drugs Accountable Officer are in place.
- The service should review medication certificates. Best practice would be to renew T2 certificates at twelve monthly intervals for T3 certificates at 24 monthly intervals. However, this was not always completed.
- The service should display information for patients detailing the payphone call tariffs.
- The service should submit data to the Mental Health and Learning Disability Data Set and Mental Health Services Data Set from January 2016.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **Dignity and respect** The Langford Centre failed to adequately assess risk and had not ensured that patients' privacy, dignity and safety were maintained. The wards were single sex, but patients of the opposite sex went onto the wards for activities. This included walking through bedroom corridors and past open bedroom doors. Female patients said they did not always feel comfortable or safe when male patients came on the ward. Staff did not ensure that patients had privacy when they received treatment. On Daffodil and Blenheim ward patients, physical health observations and weights were carried out in the lounge. Staff told us this was because the clinic room was too small and no other space was available. The Langford Centre imposed blanket restrictions on its patients. All patients were restricted because of the actions of individual patients. This included access to cutlery and crockery and food and drink. This was in breach of Regulation 10(1)(2)(a)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Person-centred care**

This section is primarily information for the provider

Requirement notices

The Langford Centre failed to ensure that they had effectively planned for discharge incorporated into patients' assessments.

This was in breach of regulation 9(1)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Good governance** The Langford Centre did not have appropriate systems in place to ensure that agency and bank staff were appropriately trained to be able to carry out the regulated activity and deliver safe care and treatment to patients. Risks were not adequately assessed, monitored or mitigated. This was in breach of regulation 17(1)(2)(2)(a)(b)(d)