Langdon Hospital

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

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.

Overall summary

During this focused inspection we inspected the safe and well led domains at Owen House and Avon House at Langdon hospital.

The service already has an outstanding rating and on this occasion we did not re-rate it.

We inspected the service due to concerns that had been raised through safeguarding and through information shared with us.

Prior to the inspection, the trust had been responding to safeguarding concerns that had been raised. Owen House had seen a high turnover of staff over the previous year. Staff at Owen House had not been identifying and reporting safeguarding previously but were now using a matrix to support this process. A new manager and a new consultant were in place at Owen House. Efforts had been made to improve training and supervision compliance. Concerns had also been raised about communication from Owen ward with care coordinators and community providers and efficiency of discharge planning. Owen House had an action plan in place to address the following areas: discharge planning, leave planning, quality reporting, absent without leave (AWOL) processes, care records, staffing, skill mix, training, safeguarding and actions to address leadership and organisation of the ward.

Summary of findings

We had received information about staffing shortages including sickness and vacancies at Avon House. These included vacancies for a substantive consultant, ward manager, social worker and occupational therapist. Although these were being covered by bank and agency staffing, we were concerned that staff were regularly being redeployed to medium secure wards at Langdon and that this was leaving Avon House with minimum staffing levels. This meant patients could not always take escorted leave they were entitled to. We understood that, in response to these concerns, the ward was holding regular team meetings and patient forums to reinforce a supportive culture.

We had asked the trust for information about the concerns raised and learned that there had been recruitment issues on both wards and the trust was addressing these with an ongoing recruitment programme. The trust told us that the senior management team were spending more time on site at Langdon hospital and holding staff engagement events to seek views from staff and patients.

During our inspection visit, we found:

- The service provided safe care. Wards were working towards improving recruitment and retention and safe staffing levels were being maintained. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.
- Staff planned and managed discharge well and liaised with services that would provide aftercare.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However

- There were blind spots on the stairwells at Avon House that had not been mitigated and there were delays in completing repairs to patient toilets, showers and telephones.
- There were staffing challenges on both wards although these had improved. There were two vacant nurse posts at Owen House and there had been a high turnover of staff over the previous 12 months. Staff from both wards were regularly redeployed to other wards and this left both wards with minimum staffing levels. Staff told us they struggled to provide a good level of service at the minimum staffing level.
- Staff did not routinely record when patients section 17 leave had been cancelled and this meant there was a lack of oversight of the extent of the issue.
- Ward and senior managers did not know that safeguarding referrals were reviewed by the trust's safeguarding department and that not all referrals were sent to the local authority.
- Patients and staff had raised concerns about the replacement of metal cutlery and china crockery on all wards with plastic cutlery and crockery. Staff considered this to be an unnecessary blanket restriction.

Summary of findings

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Services we looked at
Forensic Inpatient/Secure wards

Summary of this inspection

Background to Langdon Hospital

Devon Partnership NHS Trust provides forensic/secure inpatient wards for male patients with mental health conditions who are detained under the Mental Health Act 1983 at Langdon Hospital, an NHS forensic hospital based in Dawlish, Devon. The hospital is owned and managed by Devon Partnership NHS Trust. The Dewnans centre has 60 inpatient beds on four medium secure wards: Ashcombe; Holcombe; Warren and Cofton. The Dewnans centre supports men on treatment pathways from admission through to long term and step-down care as their health and wellbeing improves. Ashcombe is an admission and assessment ward and Holcombe is a ward for patients with complex mental health needs, which might include personality disorder. Warren and Cofton provide on-going care and treatment for patients who are still deemed to require medium secure care. Patients can move on to low secure services from all wards within the medium secure care unit. Langdon Hospital provides low secure services at Avon House, a 14 bed ward, and Chichester House, a 15 bed ward, for men with stable but enduring mental health conditions. It provides open secure rehabilitation services at Owen House, a 16 bed ward, and Connelly House, a 6 bed ward, for men with complex mental health needs.

Most patients at Langdon hospital were from Devon, Plymouth and Cornwall but the hospital provided care and treatment to patients from other counties. The hospital accepted admissions from high secure services, other secure units, adult mental health services, prison and the courts.

At the last comprehensive inspection of this core service in January 2018, we rated the wards as good for safe and responsive and we rated effective, caring and well led as outstanding.

At this inspection we inspected the safe and well led domains at Owen House and Avon House. The service was not re-rated at this inspection.

Our inspection team

The team that inspected the service comprised a CQC inspector and a specialist advisor with experience in working in forensic inpatient settings.

Why we carried out this inspection

We inspected this service due to concerns noted in the information we collect about the trust and information passed to us about safeguarding practices, discharge planning, leave planning,care records, staffing, training and leadership.

How we carried out this inspection

As this was a focused inspection, we did not re-rate the service and we looked at key lines of enquiry in the safe and well led domains. The ratings remain the same as those awarded at the comprehensive inspection 10-12 January 2018.

During the inspection visit, the inspection team:

- visited Owen House and Avon House;
- spoke with eight patients who were using the service;

Summary of this inspection

- spoke with the ward managers and senior nurse managers of each ward;
- spoke with nine other staff members; including, nurses, occupational therapists and support workers;
- looked at 12 care and treatment records of patients;
- attended a patient forum;
- reviewed staffing rotas;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with eight patients. Feedback from patients was largely positive.

Patients all told us they felt safe on the wards.

Patients told us staff were approachable. However, two patients from Owen House told us they did not know who their named nurse was. Patients said they could request one-to-one time with staff but that it was not generally offered. Two patients from Owen House and three from Avon House told us they had a key nurse who they saw regularly.

Patients told us their discharges were being planned and they were supported to make visits to potential placements prior to leaving the service. Most patients said they had visits from their care coordinators in the community except for two patients who said they did not know who their care coordinator was and had never had a visit. Patients said they took part in meetings about their care.

Most patients told us there were enough activities for them including trips off-site. Patients with unescorted leave were supported to take part in community projects and to attend college. Two patients at Avon House said there were not enough activities of interest to them.

Patient said the wards were staffed sufficiently although they were aware that staff were quite often redeployed to other wards. Three out of the eight patients we spoke with told us their section 17 leave was sometimes cancelled because of short staffing.

Patients from Avon House said the public phone for patients was broken and they had made complaints about this.

At the patient forum we attended, patients said they objected to the rollout of plastic cutlery in view of their ward being a rehabilitation ward preparing them for the community, where metal cutlery would be used.

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?

- All wards were safe, clean, well equipped, and well furnished.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply their knowledge.
- Staff had access to clinical information and it was easy for them to maintain high quality electronic clinical records.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However

- There were blind spots on the stairwells at Avon House that had not been mitigated. We raised this with the ward manager on the day of the inspection and the ward were in discussions with the trust about the layout of the building and how to address lines of site.
- There were delays in completing repairs to wards including showers, toilets and a patient telephone.
- There were two vacant nurse posts at Owen House and there had been a high turnover of staff over the previous 12 months.
- Staff were regularly redeployed to other wards and this left both wards with minimum staffing levels. Staff told us this affected their morale and impaired their capacity to take patients on unescorted leave, provide one-to-one care, provide activities and respond to other wards in an emergency. Although staff were back-filled to ensure a minimum staffing level of three, establishment levels were four per shift during the day and three at night. Back fill for nurses was by health care assistants.
- Ward and senior managers did not have a full knowledge of the safeguarding procedures for the trust and were not aware that safeguarding referrals were reviewed by the trust's safeguarding department and that referrals that did not meet the threshold were not sent to the local authority.

Summary of this inspection

- The provider had implemented a new policy that staff and patients had raised concerns about. The policy was to replace metal cutlery and china crockery on all wards with plastic cutlery and crockery. Staff considered this to be an unnecessary blanket restriction. The trust had acknowledged concerns raised and the matter was under review by the trust.

Are services effective?

We did not inspect this key question at this time.

Are services caring?

We did not inspect this key question at this time.

Are services responsive?

We did not inspect this key question at this time.

Are services well-led?

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Our findings from the inspection demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in quality improvement activities.

However

- Staff were not all familiar with the whistleblowing process and did not know who the speak up guardian was for the trust.

Staff did not routinely record when section 17 leave that patients were entitled to had been cancelled or rearranged. This meant there was a lack of oversight of how often patients' leave was being cancelled because of staffing shortages.

Forensic inpatient or secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient or secure wards safe?

Safe and clean environment

Avon House was split over two levels, with accommodation for patients on the first floor. There were blind spots on the staircases that had not been mitigated. The layout of the building was listed on the ward's risk register due to poor lines of sight across the ward. There were no reported incidents resulting from the lack of visibility.

Wards had ligature risk assessments, and these were regularly updated.

Wards complied with guidance on eliminating mixed sex accommodation because they were male only wards.

Staff carried alarms, and these were tested daily. Staff told us they thought daily testing was excessive as the alarms at Owen House and Avon House for all the neighbouring wards were tested in sequence which could take around 30 minutes. Staff said the daily sounding of loud alarms detracted from the therapeutic environment and they had reported this to health and safety and security. Four wards were grouped together to provide backup for each other during an emergency. If an alarm was raised on any of the wards, then a member of staff from the other three wards would attend providing there were more than three staff on duty.

Wards were visibly clean, and furnishings well maintained. However, at Owen House, there was only one toilet and one shower working on the floor where patients' bedrooms were located, with two showers and toilets being out of order. After the inspection the trust told us the toilets and showers had been repaired. At Avon House the patient telephone had been out of order for around eight weeks. Patients could use a staff telephone. The ward manager was planning to issue patients with basic mobile phones. This system was currently being piloted to check for network coverage and the shop on site had agreed to stock top up cards for patients to buy.

Safe staffing

Staffing establishment levels for registered nurses for each ward was 6.3 whole time equivalent. Staffing levels for support workers and assistant practitioners was 10.1 for Avon House and 11.3 for Owen House.

The current number of vacancies for registered nurses for Owen House was 2.34 whole time equivalent. Avon House had no vacancies for qualified nurses. Vacancies for support workers and assistant practitioners were at 1.1 for Avon House and 0.82 for Owen House.

The sickness rate for Avon House was 5.1%. At Owen House sickness levels had improved since November 2018 and was at 5.7%.

The turnover rate for Avon House for the previous 12 months was 14.5%. The turnover rate for Owen House for the previous 12 months was 31.8%.

Staffing establishment levels had been agreed for both wards. Both wards were staffed with four staff on early and late shifts and three at night. Both wards always maintained at least three staff on duty including one qualified member of staff at any one time. However, staff told us that when staff staffing levels dropped from four to three, for example due to sickness or staff being redeployed to other wards, they could not always facilitate escorted leave, respond to other wards in an emergency or provide one-to-one care and activities. Staff did not always complete an incident form if they cancelled or postponed patient leave so the exact extent of the issue could not be measured. However, staff told us leave was frequently postponed and rearranged. When teams were at minimum staffing levels, they prioritised therapeutic leave that had

been care planned for patients where the planned activity would aid their long term recovery. If a patient needed to be escorted to a medical appointment, managers could request extra staff in advance to ensure the appointment would go ahead. Staff prioritised taking patients on leave over taking their own breaks.

Concerns were raised by staff about staffing levels when team members were redeployed to other wards during their shifts. Managers told us that when nurses were redeployed, they were usually backfilled by unqualified staff. Staff said their morale was affected by staffing levels. The trust was advertising vacancies. Managers told us the process of recruiting new staff was often delayed by staffing shortages in the human resources department at the trust.

At Owen House, staff told us that therapeutic working relationships had suffered due to a lack of stability. A ward manager had been appointed in November 2018 and a new consultant in January 2019. At Avon House there had been three ward managers within one year.

At the inspection visit we heard that recently the use of agency staffing to provide backfill had been approved and this had improved staff morale. However, not all agency staff were trained in the restraint technique used by the wards. Managers assured us there were enough numbers of staff trained in restraint available on each shift. Agency staff that were not trained in restraint did not participate in restraints.

We looked at staffing rotas for the past three months for both wards and these showed the minimum staffing requirement was met on every shift. On both wards there was always a qualified member of staff on duty during the three-month period. Owen House had used agency staff, mainly on night shifts. We looked at incidents when qualified nurses from Owen House had been redeployed to other wards on the Langdon site and found that on each occasion, backfill was provided. Staff at Owen House said there had been an improvement over the past six weeks in staffing levels and this meant they were better able to facilitate patient leave.

We talked to the senior nurse managers for each ward and they told us they were asserting that Owen House and Avon House should maintain the agreed establishment of four members of staff on duty on each ward at any one time. Avon House and Owen House had begun to refuse to send staff to other wards in the interests of their own staff and patients morale, safety and well-being.

When patients required enhanced observations, wards increased their staffing as required, usually with agency staffing. Managers told us the process for acquiring agency staffing could be more streamlined and that they had lost the facility to appoint agency staffing and now had to gain approval.

Managers were aware that staff benefited from a mix of genders on each shift and tried to facilitate this.

The trust's restraint technique required at least three members of staff to restrain a patient. However, staff told us they felt they needed four members of staff to safely restrain a patient and that they might have to ask for help from another ward if there were only three staff on site.

Owen House staff had completed 97.5% of mandatory training and Avon House staff had completed 100% of mandatory training.

Supervision and appraisal rates were 95% for Owen House and 56% for Avon House. The new manager for Avon House said one member of staff's appraisal had been completed and another was booked for May 2019.

Staff generally told us their supervision was good quality.

Assessing and managing risk to patients and staff

We reviewed 12 care records across both wards. All patients had a comprehensive risk assessment in place and these were reviewed on a regular basis. Staff at Owen House had recently completed an audit of care records. Following this, staff had received guidance on completing care records fully. Avon House were planning an audit of care records and had already been working on making their care records more patient centred.

All care records showed comprehensive section 17 leave plans were in place for patients. There was evidence of escorted and unescorted leave taking place regularly. There was evidence of community involvement in ongoing care of patients. Patients had discharge plans where appropriate and they were supported to transition gradually to new placements with visits and stays to ensure a smooth transition.

Forensic inpatient or secure wards

There was evidence of good communication with the trust's forensic community team. On Owen House, a support worker was being given protected time to support discharge planning on a trial basis. The ward had been developing relationships with other agencies as part of its action plan following the safeguarding concerns. Care records showed wards were communicating with other providers in the community regarding facilitating discharge and updating community care coordinators.

Following the safeguarding issues raised on Owen House, staff had begun to use discharge planning checklists. Some patients' discharges were planned by the community forensic team and some by the ward teams.

Staff told us they were unhappy about changes being made to patients' cutlery and crockery. The trust was replacing metal cutlery and china crockery on all wards with plastic cutlery and crockery. The trust had acknowledged concerns raised by staff and patients about making these changes on open and low secure rehabilitation wards where patients were being prepared to live in the community. The matter remained under review by the trust. Staff told us about their concerns that the plastic cutlery was rigid and could be sharpened and that it could not be detected in a metal detector. Staff said they would continue to count cutlery in and out. The security team liaised weekly with each ward to provide advice and support.

Safeguarding

Although staff knew how and when to raise safeguarding concerns, they were not familiar with the process that took place after the request for a safeguarding referral to the local authority had been made. Staff raised safeguarding concerns with the nurse in charge or ward manager. Safeguarding concerns were reported as incidents and there was a box to tick on the incident reporting system to make a referral to the local authority. However, staff including managers and senior managers, were not clear on the safeguarding procedures and could not provide a rationale for the process that was in place. They did not know that ticking the box did not trigger an automatic referral to the local authority. There was a risk that staff who knew patients and the wards best were not involved in decision-making about how those patients were safeguarded. Managers discovered during the inspection that safeguarding incidents were first triaged by Devon Partnership Trust's own safeguarding team. However, an interim social work lead was tracking referrals to ensure they continued to be actioned in a timely manner and sometimes contacted the local authority directly if required. The lead social worker is the internal lead for safeguarding at Langdon Hospital. There were no cover arrangements for the interim social work lead but there were plans to develop safeguarding champions for each ward.

Prior to the inspection, the trust had been responding to safeguarding concerns that had been raised. As a result of the safeguarding review, Owen House had an action plan in place to address and improve discharge planning, leave planning, quality reporting, absent without leave process (AWOL), improved reporting of improved recording in care records, staffing, skill mix, training safeguarding and actions to address leadership and organisation of the ward.

CQC had received information about staffing shortages at Avon House and the redeployment of staff to medium secure wards, leaving Avon House with minimum staffing levels and preventing patients taking escorted leave they were entitled to on occasion.

At this inspection, we found that Owen House had been learning and developing following the service safeguarding review. Owen house staff had been issued with a newsletter, outlining when to complete incident forms and when and how to refer incidents for safeguarding. During the inspection we talked to both wards about staffing levels and were assured that these had improved since the concerns had been raised.

All staff were up-to-date with safeguarding training apart from two staff at Owen House who had not yet completed level three safeguarding training. Staff told us they knew how to make safeguarding alerts and felt confident in recognising abuse. There was a 'grab pack' in the ward office that contained a step-by-step process for responding to safeguarding concerns.

There was good oversight of safeguarding across the site with a monthly safeguarding committee meeting across the whole Langdon site to review all incidents with safeguarding concerns, sexual safety, violence or assault. The meeting discussed ongoing trends.

The interim social work lead had also held a training session with patients on keeping safe.

Track record on safety

Forensic inpatient or secure wards

During the 12 months 1 March 2018 - 1 March 2019, Avon house had four serious incidents and Owen house had three serious incidents. These were a death of a patient four weeks following discharge, two incidents of violent or aggressive behaviour, treatment delay caused by poor communication, a patient taking absence without leave, alleged abuse by a patient and a death of a patient whilst on section 17 leave.

There had been learning for staff following the death of a patient while they were on leave from the ward in July 2018. Wards held substance misuse groups for patients. However, the ward manager felt the team could speak more openly to recovering addicts about tolerance and the risks of them using substances again in future.

Reporting incidents and learning from when things go wrong

Staff knew which incidents to report and how to report them and had received guidance in a recent newsletter. However, staff were not routinely recording when section 17 leave was cancelled for patients.

There was evidence of staff discharging their duty of candour. Staff were open and transparent and gave patients and families explanations when things went wrong.

Staff received feedback from incidents via newsletters and team meetings.

Staff told us they were debriefed after incidents and offered support.

Are forensic inpatient or secure wards effective?
(for example, treatment is effective)

Are forensic inpatient or secure wards caring?

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

Are forensic inpatient or secure wards well-led?

Leadership

Ward managers had the skills and knowledge to perform their roles although both were new in the current roles. However, they said there was good support for them from the senior management team, especially the senior nurse managers who they described as available and responsive. There had been concerns raised about the leadership of Owen House prior to the current manager being in post and these were being addressed through the safeguarding action plan.

Leaders had a good understanding of the services they managed and could explain how the teams worked and the progress they were making to improve the standard of care.

Leaders at all levels were visible and approachable to patients and staff.

Vision and strategy

Staff had opportunities to contribute to discussions about the strategy of the service. For example, at Owen House, regular meetings had been put in place as part of the action plan following safeguarding concerns raised. These meetings included daily meetings between the consultant and ward manager, monthly governance meetings, quarterly meetings to discuss quality of care and reflection meetings with the ward psychologist to promote collaborative and transparent working within the multidisciplinary team.

Culture

All staff we spoke to said they felt respected and supported by ward managers. Staff said managers were compassionate, responsive, approachable, thoughtful and that they listened to staff. Staff said they used not to feel heard by senior management, but this was being addressed. For example, senior management had held a listening group for Owen House staff.

Staff at Owen House said there had been several recent changes but that the ward was now more settled and morale had improved. All staff said morale was good but that it suffered when staff were redeployed to other wards.

Forensic inpatient or secure wards

Staff enjoyed and were passionate about their work. Staff worked flexibly and they provided good quality care to patients. Staff described their teams as committed and cohesive.

All staff said they would raise concerns with managers without fear of retribution.

All staff said they would be prepared to use the whistleblowing process. The trust had a freedom to speak up guardian with a 24-hour phone line. Most staff, including managers, had not heard of the service but they understood their right to whistle blow. The speak up guardian service was advertised on the staff intranet home screen.

Teams worked well together. Avon House held comprehensive weekly staff meetings to discuss admissions and discharges, security, health and safety, complaints and compliments, the ward environment, medicines management, infection control, supervision, personal development and training, staffing and safeguarding. Owen House held monthly governance meetings for staff and impromptu staff meetings that focused on the day to day running of the ward.

Managers were managing sickness when required. Staff sickness rates were above the provider's target of 4.5%. At Avon House the sickness rate was 5.11% and at Owen House the sickness rate was 5.71%.

Staff were supported to access counselling as required and this was provided by the trust.

Governance

There were systems and processes in place to ensure wards were safe and clean and that there were enough staff. The trust undertakes annual safer staffing reviews. The last one was received and approved by the board in March 2019. However, this was challenged by requests for staff to be redeployed to other wards which would sometimes leave staffing numbers at a minimum level. At a minimum level of staffing, wards were unable to complete all their functions such as enabling patients to go on escorted leave. Leadership of the service ensured that staff were trained and supervised, and that staff thoroughly assessed patients' risks. There was evidence of improvement following concerns raised, for example discharge planning had improved in recent weeks and there was a plan to try to reduce patient length of stay. There had been an improvement in the oversight of and learning from incidents.

The investigation into safeguarding concerns at Owen House had reinforced the need for staff to raise safeguarding concerns appropriately. The interim lead social worker had good oversight of individual safeguarding referrals and reported on themes, trends and concerns. The interim lead social worker was following the progress of safeguarding referrals. We were concerned that managers and senior managers at Owen House and Avon House were not aware of the safeguarding process within the trust and had assumed that when they specified a referral to the local authority, it was made automatically. When managers discovered during the inspection that referrals were not automatically made to the local authority but were triaged by Devon Partnership Trust own safeguarding team, managers could not provide a rationale for the safeguarding process. The trust safeguarding policy said that referrals were reviewed by the trust safeguarding team, but staff did not feel confident that there would be agreement between Devon Partnership Trust and the local authority about what would necessitate a section 42 enquiry.

Staff had implemented improvements to the service at Owen House guided by their action plan. There was evidence on both wards that the service was learning and developing in response to feedback and incidents.

In response to feedback, Owen House had improved their relationships and communication with external providers. Both wards were systematically planning for patients' discharges. In response to the action plan, the ward was ensuring care coordinators were invited to review meetings about patients' care. The teams had strengthened the discharge planning process by ensuring actions were assigned to walls to complete. The trust's new community forensic team was having a positive impact on discharge. Wards said they had a good working relationship with the new service but that procedures needed to be clarified and regular meetings set up. The goal of the community forensic service was to reduce the length of patients' stay by six months.

Management of risk, issues and performance

Forensic inpatient or secure wards

Each ward had a risk register and risks were consistent with concerns held by staff. For example, the Avon House risk register had a moderate risk item on it from January 2018 about the ward not being staffed to an establishment of four staff on early and late shifts and three at night. Owen House's risk register included the risk of patients not being able to take section 17 leave and the risk of there being too few nurses.

Staff from Owen House had recently attended a staffing workshop to try to find solutions to issues they were experiencing such as patient leave being cancelled. Feedback about this meeting was positive.

Information management

Staff have access to information technology needed to do their work. Staff had appropriate access to care records.

Managers had access to information to support them with their management role. This included information on the performance of the service and staffing.

Engagement

Staff were kept up to date with information about the provider through an intranet and newsletters, including newsletters produced at ward level.

Patients and carers had opportunities, for example via a patient forum, to feedback on the service. There was evidence that managers and staff acted on the feedback to improve the patient experience.

Learning, continuous improvement and innovation

Avon House staff took part in reflective practice sessions to consider how the service could be improved and they had recently held an awayday for staff. Owen House were planning an awayday for May 2019 and they were planning to include some training with a mental health law trainer in response to feedback they had received about this being a training need for their staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The trust should mitigate the blind spots on the stairwells at Avon House and ensure repairs to the wards are completed in a timely manner.

The trust should review the minimum staffing levels for both wards and consider the impact on staff and patient well-being when staff were redeployed to other wards. The trust should continue to support the wards to mitigate the risks caused by high turnover of staff.

The trust should ensure there are always enough staff on duty to facilitate patients taking section 17 leave. The trust should ensure wards record when patients' section 17 leave has been cancelled to enable them to have a good level of oversight and management of this issue and to ensure patients are able to take the leave they are entitled to.

The trust should ensure staff at all levels are familiar with safeguarding procedures and have a good understanding of the procedures and involvement in decision-making about how patients are safeguarded.

The trust should continue to review and take into consideration, comments from patients and staff on the restrictions in place on open and low secure wards regarding the use of metal cutlery and china crockery.