Thornford Park

Quality Report

Crookham Hill
Thatcham
Berkshire
RG19 8ET
Tel:01635 860072
Website:thornfordpark@elysiumhealthcare.co.uk

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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	Good
Are services safe?	Good
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 rated Thornford Park as good because:

- Risk assessments and risk management plans were detailed, thorough and up to date and patients had been involved in the development of the plans. The assessment of patients' needs and the planning of their care was thorough, individualised and had a focus on recovery. Physical healthcare assessments and associated plans of care were thorough and consistently delivered to a high standard. Care plans had either a National Institute for Health and Care Excellence (NICE) guidance reference to an identified intervention or another nationally recognised intervention such as from the Quality Network for Forensic Mental Health led by the Royal College of Psychiatrists.
- There were enough suitably qualified and trained staff to provide care to a safe standard. We consistently saw respectful, patient, responsive and kind interactions between staff and patients. Staff displayed a high level of understanding of the individual needs of patients. There were innovative practices used consistently across the service to engage and involve patients in the care and treatment they received, for example, the recovery star. There was a confident and thorough understanding of relational security among all of the staff. Relational security is how staff use their knowledge and understanding of their patients to ensure the ward environment is kept calm and any conflict is kept to a minimum.
- Bed management processes were effective and there was a clear care pathway through the service from medium secure wards to the least restrictive environments, such as the shared flats. The service model optimised patients' recovery, comfort and dignity. The needs of patients were considered at all times.
- The service had clear guidance in place to report incidents and we saw evidence that staff learnt from when things had gone wrong. The service was responsive to listening to concerns or ideas made by patients and their relatives to improve services. We saw that when staff where able to, these ideas were taken on board and implemented.
- Staff monitored patients' physical healthcare and they could access specialist physical health services when needed. A GP provided regular physical health monitoring. Patients attended a well-man clinic.
- We observed many positive engagement and interaction between staff and patients. Staff demonstrated a clear understanding of individual patient's needs.

However:

- Staff were not always available to facilitate section 17 leave on the forensic wards and leave was often cancelled.
- The number of staff having access to regular supervision was below the provider's target of 90%.
- Not all patients were always reminded of their rights when their circumstances changed, such as on renewal of detention.
- The seclusion room did not have a two-way intercom to ease communication between staff and patients. Gym equipment was worn . All of these facility issues had been identified for refurbishment and upgrade in 2018
- The recording of seclusion was documented differently across the wards. Staff made the required checks however, some was recorded electronically and some in paper form.

Summary of findings

Contents

Good

Thornford Park

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards;

Summary of this inspection

Our inspection team

Team leader: Jackie Drury, Inspector, Care Quality Commission.

The team that inspected Thornford Park comprised of four CQC inspectors, one CQC inspection manager, three nurses with experience of secure, high secure and forensic services, an occupational therapist, two Mental Health Act reviewers and a consultant psychiatrist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme and because the provider had recently changed from the Priory group to Elysium Healthcare. In addition, the psychiatric intensive care unit opened in 2015 and we have not inspected this ward previously. We inspect services where a provider has recently changed.

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 the information that we held about this service.

During the inspection visit, the inspection team:

- visited the psychiatric intensive care unit and all eight of the forensic inpatient wards and the two flats and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 80 patients from the forensic inpatient wards and five patients from the psychiatric intensive care unit
- received 49 comment cards from patients
- held a focus group for patients on three wards
- spoke with the managers for each of the wards
- spoke with 88 staff members including doctors, nurses, support time and recovery workers, healthcare assistants, occupational therapists, psychologists, pharmacists and social workers
- received feedback from four relatives
- interviewed the senior management team with responsibility for these services, including the hospital director and medical director
- attended and observed four multidisciplinary clinical meetings and two patient therapy groups
- looked at 68 treatment records of patients and 95 medicine records
- carried out a specific check of the application of the Mental Health Act on three wards
- carried out two short observational framework for inspection exercises
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Thornford Park

Thornford Park Hospital in Crookham Hill, Thatcham, Berkshire, is part of the Elysium Healthcare Group.

The hospital provides forensic inpatient services and has three medium secure wards, five low secure wards and two shared flats. It is for male patients only and has a

Summary of this inspection

capacity for 119 patients. Chieveley and Bucklebury wards are the medium secure admission wards and have 10 and 12 beds respectively. Hermitage ward is a medium secure step down and treatment ward with 14 beds. Theale ward is an acute, low secure ward with a focus on intensive care and has nine beds. Highclere is a low secure ward for older adults and has 17 beds. Burghclere and Headley wards are low secure and have 26 and 11 beds respectively. Kingsclere is a low secure pre-discharge ward and has 13 beds.There are seven rooms provided in two shared flats called Ashford and Midgham providing semi-independent living beds. These are also within the hospital premises. Many of the patients had Ministry of Justice and risk related restrictions in place in relation to their care and treatment.

The Crookham unit is a purpose built psychiatric intensive care unit (PICU) for men that opened in November 2015. The Crookham unit is not part of the forensic hospital, stands outside the secure perimeter fence of the main hospital and has its own entrance. The PICU takes patients from anywhere across the country. The Crookham unit has ten beds for male patients, detained under the Mental Health Act. The unit is for patients with a mental illness who cannot be safely assessed or treated in a general adult ward. The unit has not been inspected before, but has had a Mental Health Act monitoring visit from Care Quality Commission in October 2016.

We last inspected the services provided at Thornford Park in July 2015 as part of the Care Quality Commission comprehensive mental health inspection programme and the service received an overall rating of good. We rated all the five key questions as good.

We have visited the wards at Thornford Park on 10 occasions from July 2015 through our Mental Health Act monitoring visits.

What people who use the service say

We spoke with 80 patients in the forensic service and we received 44 comment cards from patients. The majority of patients, 75%, made positive comments about their experience of care in Thornford Park. Patients told us that they found staff were caring, kind, professional and supportive towards them. Other patients felt that restrictions placed on them, through the Mental Health Act, the Ministry of Justice (for patients sent to the hospital by a court) or both made it difficult to feel positive about their relationships with staff. Virtually all of the patients we spoke with felt actively involved in looking at choices for and making decisions about their care and treatment. Patients said staff treated them respectfully and that real improvements had been made to the quality of the food provided. Patients knew how to complain and all said they had been provided with this information.

Some patients in the psychiatric intensive care unit with complex mental health needs were unable to tell us their experiences at the time of our inspection. We therefore used different methods, including observation to help us understand their experiences. We observed positive and kind interactions between patients and staff. Carers and patients told us staff were respectful, recognising the need for and importance of good communication. Patients reported that staff were caring towards them and treated them kindly, respecting their privacy and dignity. Patients said that at times there was not enough staff.

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?

Good

We rated safe as good because:

- Staff kept the wards clean and well maintained and patients told us that they felt safe.
- There were enough, suitably qualified and trained staff to provide care to a safe standard.
- Risk assessments and risk plans were detailed, thorough, up to date and patients had been involved in the development of the plans.
- There was a confident and thorough understanding of relational security among all of the staff. Relational security is how staff use their knowledge and understanding of their patients to ensure the ward environment is kept calm and any conflict is kept to a minimum.
- The hospital had clear guidance in place to report incidents and we saw evidence across all wards that staff learnt from when things had gone wrong.
- There was good medicines management practice on the PICU. A pharmacist visited the unit once a week and was available to staff for out of hours consultation.

However:

- While staffing levels were safe, staff and patients on the PICU told us that due to how unwell patients were they felt stretched.
- The seclusion room did not have a two-way intercom to ease communication between staff and patients. The seclusion room was due for refurbishment in 2018.
- The recording of seclusion was documented differently across the wards. Staff made the required checks however, some was recorded electronically and some in paper form.

Are services effective?

Good

We rated effective as good because:

- The assessment of patients' needs and the planning of their care was thorough, individualised and had a focus on recovery.

Summary of this inspection

Physical healthcare assessments and associated plans of care were thorough and consistently delivered to a high standard. Staff maintained ongoing physical health monitoring of patients.

- Every one of the 68 care plans we looked at had either a National Institute for Health and Care Excellence guidance reference to an identified intervention or another nationally recognised intervention such as from the Quality Network for Forensic Mental Health led by the Royal College of Psychiatrists. The hospital had a quality improvements committee, which reviewed National Guidance, and recommendations on interventions and ensured staff were updated.
- Throughout all of the wards the multidisciplinary teams were consistently and proactively involved in patient care. Clinical meetings were effective and patient focused and attended by a range of professionals.
- Staff training and professional development opportunities were good quality and offered to, and taken up by staff.
- Patients said they had good access to advocacy and advocates visited all the wards regularly.

However:

- Not all patients were always reminded of their rights when their circumstances changed, such as on renewal of detention.
- Staff having access to supervision was 10% below the provider's target of 90%. Crookham unit needed to improve staff appraisals to ensure these were occurring annually but we did not see any adverse impact as a result of this.

Are services caring?

Good

We rated caring as good because:

- Patients said staff were very caring, approachable and took a real interest in them. Carers we spoke with said that staff were very respectful. We consistently saw respectful, patient, responsive and kind interactions between staff and patients.
- There were innovative practices used consistently across the service to engage and involve patients in the care and treatment they received, for example, the recovery star.
- Staff took time in their interactions with patients, pre-empting when a patient was becoming distressed, using distraction techniques and demonstrating a real understanding of the patients as individuals.

Summary of this inspection

- All staff were confident and clear in how they were involving patients, family members and carers in all aspects of their care. Staff displayed a high level of understanding of the individual needs of patients.
- Patients were involved in giving feedback about the unit and were involved directly in meetings about the meals and food offered.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were not always staff available to facilitate section 17 leave for patients as agreed in their care plans in the forensic inpatient service. Leave was often cancelled which caused frustration and had an impact on patients, mood, well-being and potentially on their recovery.
- The gym equipment was worn,however it was fully serviced on an annual basis.There was also new individual pieces of gym equipment on each ward.

However:

- Bed management processes were effective and there was a clear care pathway through the forensic service from medium secure wards to the least restrictive environments, such as the shared flats.
- Generally, the service model optimised patients' recovery, comfort and dignity. The needs of patients were considered at all times. There was a varied, strong and recovery orientated programme of therapeutic activities available over seven days, every week.
- The hospital was responsive to listening to concerns or ideas made by patients and their relatives to improve services. We saw that when staff were able to, these ideas were taken on board and implemented. Staff knew how to deal with complaints appropriately. Carers we spoke with all knew how to raise a complaint.

Are services well-led?

Good

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We rated well-led as good because:

- Staff we spoke to understood the vision and direction of the organisation. Staff were able to discuss the philosophy of the wards.

Summary of this inspection

- Governance systems were in place with comprehensive clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented on a dashboard for managers, so they could monitor their progress and achievements.
- Clinical audits were regularly carried out by staff to ensure treatment and therapy was effective. Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.
- Patients told us that they were encouraged by staff to participate in making suggestions towards improving many aspects of the service. All staff and patients knew who the senior management team were and felt confident in approaching them if they had any concerns.
- The hospital leadership team were visible and regularly visited the wards. There was evidence of a strong link between the senior team and the provider and oversight of the hospital at board level. Investments had been made into the new electronic systems and capital expenditure to improve the hospital facilities. Staff spoke very highly about their management teams and there was evidence of clear leadership at ward level. The culture on the wards was open and encouraged staff to bring forward ideas for improving care. Staff spoke of a commitment to offering a good service to patients. Staff said good team work was important so they could do their role.
- Staff demonstrated a good understanding of the organisation's visions and values. Staff were aware of the whistle blowing process and felt able to raise concerns.

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.

- Staff demonstrated a good understanding of the legislation however only 65% of staff in the forensic service had received updated training on the Mental Health Act, including the revised Code of Practice, which is 15% below the provider's target. Patients were not always reminded of their rights when their circumstances changed, such as on renewal of detention All staff on the psychiatric intensive care unit had received training in the Mental Health Act. Mental Health Act paperwork was stored appropriately and staff had access to this when needed.
- We checked some of the files of detained patients on all of the wards and carried out a specific Mental Health Act review on Bucklebury, Hermitage and Burghclere wards to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act and associated Code of Practice and in most cases, this was correct. Regular ward audits of Mental Health Act paperwork were carried out and this enabled staff to ensure that the requirements of the Act were being met. Detention papers were available for inspection and were in good order.
- Mental Health Act paperwork was all securely stored. Staff routinely read detained patients their rights under section 132 of the Mental Health Act and updated their records accordingly. The Mental Health Act administrator scrutinised all legal paperwork on admission. The nurses in charge of each ward had access to an electronic dashboard, which included Mental Health Act information such as when patients needed reminding of their rights, when consent to treatment status needed reviewing and when periods of detention needed renewing. Staff were aware that they could contact the provider's Mental Health Act administrator and that they were available for guidance, training and support to the staff on the ward.
- Specialist independent mental health advocacy (IMHA) was available to all patients, IMHAs visited the unit on a regular basis.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy in place. Staff had a good understanding of the MCA although only 64% of staff in the forensic service had updated training which was 16% below the provider's target. All staff in the psychiatric intensive care unit had received Mental Capacity Act training. Staff knew where to get advice regarding MCA, including DoLS, within the hospital. Where required, Deprivation of Liberty Safeguards applications were made.
- There were arrangements in place to monitor adherence to the MCA within the provider.
- For patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions, and patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the patients' wishes, feelings, culture and history.
- Specialist independent mental capacity advocacy was available to all patients.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Forensic inpatient/ secure wards	Good	Good	Good	Requires improvement	Good	Good
Overall	Good	Good	Good	Requires improvement	Good	Good

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good

Safe and clean environment

- Crookham unit was purpose built as a psychiatric intensive care unit two years ago. The unit layout allowed staff to observe all areas of the unit. There was one blind spot on the ward, which was covered by CCTV. Staff mitigated risks by increased observations.
- Staff had carried out a ligature and ligature anchor point risk assessment and this was reviewed yearly. Patients' bedrooms, toilets and bathrooms had reduced ligature fittings in situ. The activity rooms had shelves that were identified as ligature risks, but these rooms were used under staff supervision and locked off when not in use. Risks were assessed and managed through observations and knowledge of individual patients.
- Crookham unit was a single sex unit for men, so there were no issues with mixed sex accommodation.
- The unit had a fully equipped clinic room with accessible resuscitation equipment and a medicines fridge. All necessary emergency drugs and equipment were present, recorded clearly, labelled and in date.
- The seclusion room was situated at the far end of the unit. The room was being used by a patient throughout our inspection. A seclusion room is used to contain a patient when their behaviour becomes a risk to themselves and to others. The seclusion suite was designed to allow entry from outside the unit to preserve privacy and dignity on admission.
- The unit and surrounding areas were clean, spacious and well maintained. Posters prompting good infection control were on display. Staff completed daily cleaning schedules, which were displayed on the unit.
- Staff carried alarms at all times to alert other staff to respond in an emergency. One staff member was in charge of security on each shift. On entering the unit, staff gave in their identification badge and were given an alarm. The number of this alarm was recorded by the security nurse.

Safe staffing

- Staff worked a 12.5 hour shift pattern. There were two qualified nurse on each shift and four health care assistants during the day, three at night. The service had specified the safe staffing level for each shift.
- There were five health care assistant vacancies. The unit had filled all qualified nurse vacancies and the remaining qualified nurse would start in post by the end of November 2017. There were two regular agency nurses who were on 'block booking'. Wherever possible the unit used the same bank staff to maintain continuity and ensure that the staff and patients were familiar with each other. The unit manager was able to book agency staff directly when needed.
- Staff said that the unit was extremely busy and patients were really unwell which often left staff feeling under pressure and stretched. Staff told us that the manager for the unit was very aware and supportive of the situation and helped when this was the case. The senior management team were aware of the situation and were continually monitoring and looking at initiatives to address the situation.
- There was a clear effort by staff to keep their time in the unit office to a minimum and this meant that staff had a

visible presence on the unit at all times. This included at least one qualified nurse on the unit at all times. Patients commented that they felt safe on the units because of the presence of staff.

- The unit had a consultant psychiatrist and junior doctor. Both were on call to respond and attend the unit in an emergency. Medical cover was provided by a GP who attended the hospital and patients on Crookham could access the weekly GP clinic. The on call GP would attend if required.
- All new staff, agency staff and bank staff had access to all mandatory training courses. Mandatory training covered nine areas such as Infection control, information governance, relational security, life support and food hygiene. The organisation encouraged staff to access specialised training such as the leadership and management qualification.

Assessing and managing risk to patients and staff

- For the period April 2017 to October 2017, the unit had 17 episodes of seclusion. There were no episodes of long-term segregation. Staff maintained all appropriate checks and records.
- There were 25 incidents of restraint involving 12 different patients in the period April 2017 to October 2017. Of these, three restraints were in the prone position and none resulted in the use of rapid tranquilisation. If rapid tranquilisation was used, physical health checks and additional monitoring would be carried out. Staff were trained to use prone restraint as a last resort and staff told us this would only happen in an emergency. A patient would only be prone at the beginning of the restraint. The hospital had recently implemented individual patient positive behaviour support plans, this identified the patient's strengths and difficulties and detailed individualised support interventions to reduce incidents. Patients were involved in developing their risk assessments.
- Since the unit opened two years ago, there had been two incidents of absconding. Following a review of these incidents, changes had been made, anti-climb fencing had been fitted to the roof of the unit, and there had been a review and update of the absent without leave procedure.
- Staff carried out comprehensive patient risk assessments using recognised risk assessment tools, which included historic information as well as short-term assessment of risk and treatability. Staff included factors which protected patients wellbeing. Staff updated risk assessments regularly. Patients were asked to risk assess themselves.
- Staff followed detailed observation policies on the unit. Each shift had a named staff member who was responsible for security for the shift. Staff completed and recorded patient observations, we observed staff carrying out one to one observations. If patients required a higher level of observation, this was discussed in the handover and the nurse in charge allocated this role within the shift numbers.
- There were no incidents of rapid tranquillisation between April 2017-October 2017. There were monthly reviews of rapid tranquilisation by the medical director. The staff had rapid tranquillisation training provided by the visiting pharmacist.
- Staff were trained to use de-escalation techniques. The 'Safe wards' initiative had been introduced and staff were receiving training on implementing interventions from the initiative. Physical interventions were only used as a last resort and if they were needed, staff said they would try to manage this in a planned way. Senior staff said that there was continuous training done on the unit. Staff were able to build on their experience as they observed techniques from senior staff. Senior staff modelled good practice, demonstrating the importance of using interventions at the earliest opportunity and gaining an understanding of individual patients and their triggers. The hospital had a reducing restrictive practice strategy, and staff took part in a monthly restrictive practices forum.
- Staff understood the providers safeguarding process. Staff said they would raise a safeguarding alert and knew about the internal form that needed to be completed. The unit had a dedicated social worker who was the first point of contact for staff with any safeguarding issues. The social worker then discussed concerns with the safeguarding lead for the hospital. The hospital had good links with the local authority and regularly discussed safeguarding concerns with them. The hospital had a quarterly safeguarding meeting involving the local authority.
- Patients were able to meet with visitors in private and quiet rooms were available on the unit. Visits were risk

Acute wards for adults of working age and psychiatric intensive care units

Good

assessed in advance. There was also a visits room just outside the entrance to the unit, which meant that visits could be managed and still go ahead, even if the unit was unsettled.

Track record on safety

- For the period January 2017 to November 2017 there were no serious incidents on Crookham. Incidents that are identified as serious include assaults on staff or patients, when a patient is absent from the unit without leave, a patient death or serious self-harm. For the period April 2017 to October 2017, Crookham recorded 122 incidents.
- The hospital had an incident reporting system in place. The system is an electronic record of all incidents, each incident report is completed by a staff member and reviewed by senior management. This process was in place to ensure information and learning from incidents were communicated to all staff members and changes in practice were implemented where necessary.
- Following a previous safeguarding issue at Crookham Unit, changes had been made to improve the communication, supervision and monitoring of staff. All new staff met with the senior manager; suggestion boxes were on the unit for staff and staff have been on a team-building day. The level of safeguarding training had been increased to ensure staff had a more in depth knowledge. If there was conflict with staff or a staff member had been assaulted the staff member could be moved onto another ward in the main hospital.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and what needed to be completed on the electronic system. Incidents were discussed in the daily handover. If there was an incident with a patient, the electronic system would automatically transfer this to the patient's care notes.
- Incidents were reviewed in the multi-disciplinary meeting, investigations identified learning points and these were shared across the team. All learning was reviewed within the monthly hospital clinical governance meeting and any learning was fed back to the unit. Action plans were reviewed monthly at the hospital clinical governance meeting to ensure learning was shared and actions completed and closed off. Key learning points were also highlighted in a monthly clinical governance bulletin, which was circulated to all wards and departments in the hospital and placed on the staff notice boards.
- Following incidents staff were offered a de-brief with managers and there was a reflective practice group facilitated by psychology.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed five care records. Staff had completed timely and comprehensive assessments after admission. On admission, an initial care plan was completed by the doctor and nurse, which staff reviewed with the patient and the multidisciplinary team to develop the ongoing care plan.
- Staff carried out physical health assessments with patients immediately upon admission and followed up physical health needs at each multidisciplinary team (MDT) meeting. Patients physical health was reviewed and monitored as a well-man's clinic which was held fortnightly.
- The unit had just introduced the National Early Warning Score tool (NEWS). This was an assessment monitoring and auditing tool used for patients who are acutely unwell. However, we found that it was not always recorded when a patient declined physical observations. Staff told us that observations were recorded on a patients care notes.
- The service utilised an electronic patient recording system called care notes to record and store patient correspondence. This system ensured safe storage of personal information.

Best practice in treatment and care

- Staff used National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines and involving patients in decisions about prescribing medications. NICE guidance was also used in the delivery of the therapeutic programme, which included

nationally recognised treatments for patients with needs associated with their illness. The relevant NICE guidance was referred to on the individual patient's care notes.

- Patients had access to a range of psychological therapies such as cognitive behaviour therapy, occupational therapy, drama and movement therapy, music therapy, art therapy, dialectical behavioural therapy and these were delivered via one to one sessions and in groups.
- The unit had access to the GP clinics held in the main hospital. Physical health needs were identified at the pre-admission stage and the physical health care nurse could participate in developing the physical health assessment, evaluation and treatment plan. At the point of admission, the admitting clinician completed a physical health check assessment. The physical health nurses completed routine blood tests and other baseline screening such as weight and height.
- The hospital had a quality improvements committee who were responsible for reviewing and amending procedures to bring them in line with National Institute for Health and Care Excellence (NICE) guidance. Mandatory physical examinations were monitored at a monthly medical advisory committee and these were recorded on the electronic care notes system on a dashboard so all-important information can be seen at a glance.
- Staff used recognised rating scales, such as the health of the nation outcome score (HONOS) to measure patients' progress on the unit.

Skilled staff to deliver care

- The staff on the unit came from a range of professional backgrounds, including medical, nursing, psychology, social work and occupational therapy. A pharmacist visited the unit weekly, was available out of hours for advice and was a member of the hospitals clinical governance and medical advisory committee.
- Staff supervision rates were at 92%. Although appraisal rates were low at 46%, six staff on the unit were still within their probationary period. Managers said that this should be better, staff supervision happens continually throughout the shift but this is not always captured. There was a monthly reflective practice group facilitated by the psychology team. Staff told us they felt much supported by the current manager and that they could approach them at any time if they needed to discuss anything.
- Staff had access to a wide range of learning and development opportunities. Health care assistants were doing their nurse associate training.

Multi-disciplinary and inter-agency team work

- Regular and fully inclusive team meetings took place. Multidisciplinary meetings occurred daily, we observed these meetings and found that patients were discussed in detail. Staff were knowledgeable about their patients. The meeting looked at patients' interactions with others, management strategies and review of observation levels.
- There was evidence of strong inter-agency work between the unit and the commissioners and referrers. The multi-disciplinary team sent a weekly update to the referring care co-ordinators. Social workers at the hospital had strong links with local authorities and the police.

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

- Mental Health Act training was part of the mandatory training for staff. All staff had received training on the Mental Health Act (MHA) including the revised Code of Practice. This was currently on line training.
- There was a Mental Health Act administrator within the hospital to provide support to staff on all the wards.
- Patients said they had their Section 132 rights read to them on admission and routinely thereafter.
- All patients had access to the independent mental health advocate and they visited once a week. Patients said they had spoken with an advocate and that they visited the unit regularly. The advocate was introduced to all patients on admission to the unit and posters were clearly displayed giving information and contact details for the advocacy service.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act training was part of the mandatory training for staff. 64 % of staff had received training and the hospital predicated that this would improve to 90% by the end of the year, as staff were now booked on.

Acute wards for adults of working age and psychiatric intensive care units

Good

- For patients who might have impaired capacity, there was evidence that staff assessed and recorded capacity appropriately. Doctors said that all patients are assessed within the first two days of admission.
- Staff audited the use of consent to treatment and capacity documentation to ensure staff were adhering to the principles of the Mental Capacity Act.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- Staff treated patients with dignity and respect. Staff demonstrated a caring attitude towards the patients. We saw many positive interactions between staff and patients. Patients had weekly unit and user group meetings we were shown the minutes of these actions that were brought up from these meetings were responded to.
- Some patients were unwell and agitated at the time of our inspection and the unit needed to manage a patient in seclusion. We observed staff responding and giving individual time to patients who were distressed. Staff offered reassurance and used appropriate de-escalation techniques, showed an awareness of managing potential risks, and demonstrated a real understanding of the individual patient needs.
- Patients were very complimentary regarding staff attitudes, they told us that staff were very caring, approachable, and took a real interest in them.
- Carers we spoke with said that staff were very respectful, caring and kept them informed.

The involvement of people in the care they receive

- A weekly unit round was held to review and discuss each individual patient and any issues on the unit or forward planning. Patients could attend if this did not cause them too much distress. Families and carers were invited to care programme approach meetings where appropriate.
- All staff were confident and clear in how they were involving patients, family members and carers in all aspects of their care to ensure they received sufficient information to make informed decisions.
- Patients said that they could contact an advocate when they needed to and we saw information about the advocacy services clearly displayed on the unit with contact telephone numbers. We saw from patients' records that carers and advocates were sometimes present at meetings.
- The hospital had conducted a patient survey and carer survey for the whole of the hospital. This helped to identify areas of improvement, for example, the catering manager would attend quarterly patient meetings on all the wards and carers awareness training had been included as part of the new staff induction programme. Patients also attended a food forum meeting to give feedback to catering staff about the quality of the food.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- Bed occupancy levels for the unit over the six-month period from April 2017 to October 2017 were 76 %. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients.
- The Crookham unit took referrals from all over the United Kingdom. Referrals were looked at within an hour of receipt.
- The average length of stay for patients was three to four weeks. The longest stay had been six months. However, there was no process available on the unit to highlight a delay in transfer back to the patient's home area. This meant that patients could stay longer than needed.

The facilities promote recovery, comfort, dignity and confidentiality

Acute wards for adults of working age and psychiatric intensive care units

Good

- Crookham unit is a purpose built building. The service had a space for patients to meet visitors and access to an outside space. Patients had good access to a range of activities and facilities.
- Patients felt able to have phone calls in private and had access to a patients phone. Patients could have access to mobile phones, which were risk assessed for each individual.
- Patients had access to drinks and snacks twenty four hours every day.
- Food choices and dietary requirements were always respected and unit staff had a good liaison with the catering team to pass on any requirements. Patients told us they liked the food and the catering team responded to request from the community meetings.

Meeting the needs of all people who use the service

- The ward had adapted bathrooms to enable disabled access and there was one disabled bedroom larger than the others with an ensuite wet room with bariatric facilities, this means that patients who are severely overweight could be cared for.
- Staff told us they could access interpreters easily if needed and had immediate access if required to a telephone interpreting service language line.
- The service had a separate spiritual room away from the unit that patients could request to use.

Listening to and learning from concerns and complaints

- Staff knew how to handle complaints appropriately. Staff said that they would try to resolve complaints locally at unit level in the first instance. If a complaint could not be resolved, this was escalated to the unit manager we saw evidence of complaints that had been responded to.
- Two complaints had been received during 2017. The unit had a complaints log, which recorded feedback on how the issues were resolved. Each complaint was fully investigated learning points were identified and fed back to the person making the complaint.
- Patients knew how to complain and staff were using this feedback to make improvements where needed.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- The hospital's visions and values were displayed on the unit. Staff agreed with the vision and values that were in place and understood the direction of the unit. This was part of the induction training for new staff.
- The staff spoke highly of the unit manager and they felt well supported. Staff were aware of senior managers within the hospital and said they did visit the unit.

Good governance

- Staff had a very extensive mandatory training programme covering 22 areas from health and safety on line training to face to face physical security. This was overseen within the senior management team in the hospital and all staff spoke of regular contact with them by management to ensure they remained on top of their training.
- The hospital had good systems in place to audit incidents, complaints, patients records and ensure staff appraisals and supervision were occurring and up to date.
- Senior staff had a good understanding of the challenges for the unit staff and were very aware of concerns expressed around low staff numbers. Safe staffing levels were monitored on a shift by shift basis using a recognised safe staffing tool.

Leadership, morale and staff engagement

- Staff were aware of the whistle blowing process and felt able to raise concerns without fear of recriminations.
- All staff expressed a real commitment to offering a good service to their patients, teamwork was good and important so they could do their role. Staff did not feel that the senior management team always understood the stresses they had been under with how busy the ward was. An example was given of a staff member attending a senior management meeting and it was

only at this point they realised the senior management team were aware. There was awareness from the senior management team when we fed back to them while on Inspection.

Commitment to quality improvement and innovation

- The team at Crookham unit have signed up with The National Association of Psychiatric Intensive care units (NAPICU), the Royal College of Psychiatrist accreditation scheme of which Crookham are working towards.
- The unit was working with the 'safe wards' model. This is a model introduced to look at using methods of intervention so staff can reduce restrictive practices. Staff we spoke with were aware of this model and were familiar with the use of safe wards

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

.Safe and Clean ward environment

- Staff ensured the physical and procedural security at Thornford Park was provided to a consistently good standard. Staff were knowledgeable about the provider's policies and procedures and applied these effectively, to ensure the safety of patients, visitors and staff.
- There was a single main entrance to enter and exit the hospital with a double airlock operated by a central control room, called, 'the Lodge'. An airlock is an additional locked room to pass through before gaining access or exit to or from the hospital. This strengthens security in and out of the hospital. Thornford Park had a dedicated security team who co-ordinated the entry and exit of all staff, patients and visitors. There was a separate dedicated entrance for staff, which also had an airlock and was centrally controlled and monitored. Staff signed into reception using automated fingerprint recognition. The entrance environment for patients, visitors and staff was welcoming, with comfortable furniture, lockers for storing personal belongings, cold water to drink, bathroom facilities and a variety of relevant leaflets and information. There was a high degree of professionalism from the security staff and the area operated efficiently.
- All areas of the hospital were within the secure, external perimeter fence and a circulation route was available, enabling access for patients and staff around the whole site. Closed circuit television was used to record any activity around the perimeter fence and staff maintained records of daily perimeter fence inspections. Additional maintenance required and upgrades to areas of the perimeter fence had been scheduled into the capital works programme.
- The provider had a key management system in place. Staff were issued with keys after the completion of a security induction and after presentation of valid identification. Keys were held securely in staff belt pouches and the provider kept an updated list of approved key holders. Staff collected their keys from 'the Lodge' at the start of every shift and handed them in before leaving the hospital.
- The layouts of the wards enabled staff to observe the majority of the ward areas. Where observation was restricted, staff had put risk mitigation plans in place, for example with parabolic mirrors. Burghclere ward, with 26 beds, was a particularly long ward. Staff explained they used enhanced staff presence and visibility to mitigate the associated risks of such a large ward area. Staff managed these challenges through thorough individual risk assessments and regular checks of patients and there were sufficient staff available to increase the observation of patients at a high risk of self-harming.
- All wards had detailed ligature risk assessments. These contained detailed actions to be taken to reduce risks. Anti-ligature works were being implemented across the hospital, whilst bedroom refurbishments were taking place on a planned basis. The hospital was undergoing an improvement schedule to up-grade the anti-ligature specification of each patient's bedroom and ensuite. At the time of our inspection, all but two of the medium secure bedrooms had been completed and the two

remaining were in the process of being completed. Nine low secure rooms had also been identified for the higher anti-ligature specification and these were due to commence imminently. Additional up-grade work was planned for 2018.

- Staff had received training on managing ligature risks and staff knew where the high-risk ligature anchor points and ligatures were and how these risks were mitigated and managed. Staff had carried out ligature risk assessments using the provider's ligature audit tool at least once each year. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounges and dining rooms and ensured they regularly monitored these areas. Ligature cutters were easily accessible in the wards' clinic rooms, the managers' offices and nursing offices. Any new risks staff identified were reported through the provider's incident reporting system and were escalated onto the service line risk register. Staff reduced risk by individually assessing patients and increasing their levels of staff observation if required.
- All wards were gender specific and male only and therefore complied with the guidance on same-sex accommodation.
- Each ward had a clean and tidy clinic room. Staff kept appropriate records which showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the clinic rooms. Four automated external defibrillators and anaphylaxis packs were in place across the hospital site and clear signage was available as to the locations across the site. Staff knew how to use the equipment. The wards had access to an electrocardiogram machine. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally. Equipment such as weighing scales and blood pressure machines were regularly calibrated and the equipment was checked on a regular basis. Not all of the clinic rooms had an examination couch and, if required, doctors and nurses examined patients in their bedrooms.
- Thornford Park had one seclusion suite, sited between Chieveley and Bucklebury wards which was located away from main thoroughfares and was in an area that was not visible to other patients. The seclusion suite had a large reception or de-escalation area and the seclusion room was more than 15 square meters in size (recommended size). There were good sight lines for observation throughout the suite. There were staff present throughout a period of seclusion and the staff were able to see and hear the patient at all times. However, there was no two-way intercom system available which meant it could be difficult for patients to speak with staff easily.
- The seclusion room had natural light, air conditioning, toilet and shower facilities, digital lighting and a visible clock, which also had the date on show. Safe, tear-proof clothing and bed linen were available for use. Large beanbags were used during restraints to lessen the likelihood of injury to the patient and attending staff. The seclusion suite had tamper-proof mechanical and electrical services fittings. The lighting, water and electrical override controls were external to the suite.
- A metal hatch on the bottom of one of the seclusion room walls was used to pass through food, water and medicine to patients. We questioned whether this could be demeaning for patients and discussed this with staff. Staff told us that the ability to pass items of refreshment or medicine through to the patient, without the additional stimulation of opening the door, had achieved a reduction in violent incidents in the suite. This seclusion suite was due to be refurbished as part of the capital works programme in 2018.
- Thornford Park had two additional extra care areas on Theale and Hermitage wards. These areas were used for de-escalation and provided a quiet, low stimulus space, for patients experiencing high levels of arousal who did not require a period of seclusion. The areas were used appropriately and in keeping with the Mental Health Act Code of Practice guidance. The rooms had a small lounge area and ensuite bedroom. The Theale room was not being used when we visited due to being damaged. There were plans in the capital works programme to turn both of these areas into seclusion suites. This meant that any patient in a low secure ward would not have to be moved to a medium secure ward for the period of seclusion.

- We had concerns at our previous inspection in 2015 that all of the ensuite showers on Highclere ward could not be used. A health and safety audit had concluded that the step up showers were a significant risk to slips, trips and falls. This was particularly pertinent given that over half of the older patients on Highclere had mobility needs identified. The showers were being refurbished into level wet rooms, one at a time. There are three permanent communual bathroom facilities within Highclere ward that patients can utilise whilst other refurbishment works take place. At the time of this inspection 10 of the showers were accessible and in use. Two further showers were scheduled in the capital works programme for full refurbishment in 2018.
- All wards were well maintained and clean throughout. Furniture, fixtures and fittings were of a good standard, for example, the provider had recently ordered 10 new chairs for frail and older patients on Highclere ward.
- Staff conducted regular audits of infection prevention and control and staff hand hygiene to ensure that patients, visitors and staff were protected against the risks of infection. Although 50% of housekeeping staff posts were vacant, contingency plans had been put into place to ensure the level of cleanliness across the hospital was maintained. In October 2017, this had been escalated as a risk onto the hospital risk register. Staff carried out a range of environmental and health and safety audits and risk assessments, including checks on standards of cleanliness.
- Alarms were available in each room on the wards and all staff carried alarms. We were told by staff that alarms were responded to in a timely manner and this is what we saw when an alarm was activated. Where alarms were inactive, such as in the ward gardens and the administration floor, two-way radios were used by staff to ensure safety and good communication.
- All wards participated in regular health and safety meetings and an overarching hospital meeting took place monthly.

Safe Staffing

- The number of nurses and healthcare assistants identified in the staffing levels set by the provider matched the number on all shifts across all wards. The staffing establishment on each of the wards were individually set to meet service user needs. The agreed staffing establishment enabled the ward staff to provide the day-to-day care of patients safely. Two lead nurses were available across the wards who directly supervised each of the ward managers. Ward managers were additional and not counted in the numbers three out of every four weeks each month. In addition, a supernumerary night shift co-ordinator was available.
- The nurse in charge of each ward entered the planned staffing numbers for the shift and the actual numbers on duty for that shift. These were then reviewed each day and night by the ward manager or the lead nurse and were assessed as 'safe', 'staffing numbers unmet but safe' or 'unsafe'. If 'unmet but safe' was assessed this meant that other measures had been put in place to mitigate any risk, for example, the ward manager may work in the numbers for that particular shift. We looked at a three-month audit, which showed that less than 3% of shifts were deemed to be 'unsafe'.
- We spoke with 78 staff and 32% of those spoken with said there were not enough staff to meet all of the patients' needs. These staff said, at times, activities and some patient leave had to be deferred until a later time or day. Staff told us this was often due to how unwell some of the patients were, on some of the wards, often known as 'high acuity'. This meant patients may be put onto enhanced observations such as one staff to one patient and up to three staff to one patient. In order to facilitate this staff could be called on to move from their own ward to assist on another ward.
- Staff told us it was not always possible to escort patients on leave at the particular time they required. Staff prioritised arranged appointments and family visits. Staff tried to keep cancellations of escorted leave to an absolute minimum, however there were occasions when 'social' leave, for example, for a coffee in town had to be deferred. When this happened, the provider kept a record of the incident. Staff showed us these records and in June 2017, two leave incidents occurred, in July 2017, 14 incidents, August 2017, nine incidents and in September 2017, 28 incidents occurred. The hospital senior management team had recognised that incidents of deferred leave were increasing. The managers had visited the wards to talk to staff and patients about this and to put plans in place to reduce incidents of deferred leave, such as increasing staffing. We spoke with 80 patients and received 44 comment cards. Of these, 18% of patients highlighted leave as an issue for them.
- The total number of staff across the eight wards was 93.5 whole time equivalent (wte) qualified nursing posts and 134 wte health care assistants and additional bank

staff. There were 20% vacancies, 23% for nurses and 14% for health care assistants and managers were actively recruiting to fill these posts. The staff turnover was 20%. The average staff sickness rate across the hospital was 7.5%. Senior managers told us what they were trying to do to recruit and retain more staff. For example, offering welcome bonuses, offering additional allowances, recruitment events, leaflet drops, radio interviews and adverts and increasing flexible working practices.

- When bank and agency staff were required, managers chose temporary staff who were familiar with the wards, wherever possible. The provider had block booked 11 qualified, agency staff to work across the hospital to fill nurse vacancies. These staff had received the same induction, mandatory training and clinical supervision as other employed nurses. They were members of the clinical teams and took on full roles and responsibilities.
- Staff told us senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required. We saw examples during our visit of extra staffing being made available. For example, to provide enhanced levels of observation of patients. However, as already mentioned, this could mean taking staff from other wards, which presented those wards with additional pressure. Overall safe staffing levels were maintained.
- Qualified nurses were present in communal areas of the wards at all times. There were sufficient qualified and trained staff to safely carry out physical interventions. All nurses were trained to deliver intermediate life support and all staff were trained in basic life support.
- The wards had adequate medical cover over a 24 hour period, seven days a week. Out of office hours and at weekends, on-call doctors were available to respond to and attend the hospital in an emergency. Consultant psychiatrists provided cover during the regular consultant's leave or absence.
- The provider classed nine training courses as mandatory for all clinical staff. Over 75% of staff had completed this training, which included relational security, the prevention and management of violence and aggression, moving and handling, fire safety, safeguarding, infection control, basic life support, intermediate life support and automated external defibrillator training. However, 65% of staff had up to date Mental Health Act and Mental Capacity Act training, which is below the provider's target of 80%. The provider had implemented a new information system to capture training compliance and was still completing data quality checks on the system at the time of our inspection.

Assessing and managing risk to patients and staff

- In the preceding six months to our inspection, there were 29 incidents of restraint with 12 patients and four of these restraints were in the prone position. Prone restraint is a face towards the floor position which should be avoided as it can compress a person's ribs and limits an individual's ability to expand their chest and breathe. Additionally, a person who is agitated and struggling needs extra oxygen and they are unlikely to get sufficient oxygen in the prone position. Of the 29 incidents of restraint across six wards, this involved 12 patients. One of the prone restraints involved rapid tranquilisation. Staff carried out appropriate physical healthcare checks.
- The 'in charge' electronic dashboard, available to managers, contained a report detailing the total number of restraints undertaken, the types of holds included and if the prone position was used. The current prevention and management of violence and aggression training provider was new and staff were currently transitioning to a new model, which promoted the use of a supine restraint position to minimise the use of a prone restraint. A four-stage restraint model was taught, which promoted standing and seated restraint over floor based restraint. The training included positive behaviour support training and comprehensive conflict resolution skills that focussed on de-escalation to minimise the use of physical intervention.
- In the preceding six months to our inspection, there were five episodes of long-term segregation (LTS). We looked at these instances in detail. All had a clear rationale for the commencement of LTS, with evidence that it was necessary as a 'last resort' of managing disturbed behaviour. Detailed care plans were in place and focussed on what needed to be achieved to end LTS, by patients and by staff. Considerations had been made on how to nurse the patients in the least restrictive manner possible in the circumstances, including access to fresh air, occupational therapy input, activities and opportunities for human contact. Two

patients subject to LTS were inappropriately placed at the hospital and were awaiting assessments and acceptance into a different hospital, for example, a move to a higher security setting.

- There were 25 incidents of seclusion, over the preceding six months, 10 on Theale ward, nine on Bucklebury ward, five on Chieveley ward and one on Kingsclere ward.
- We looked at the seclusion policy. At the time of our inspection, some seclusion episodes were recorded on paper and some on the electronic patient record. This made it difficult to locate the historical records. We found some gaps in five of the seven records we looked at as the papers were not filed in chronological order. The format for recording was therefore not consistent across the wards. Managers told us that the electronic patient record system had been adapted to meet the seclusion recording requirements and future recording of seclusion would be on the patients' electronic notes. We were confident that once this system was in place the records would be able to be documented and accessed more easily.
- Where a patient from a ward required seclusion the patient would need to be transferred to the suite. The hospital called this a restricted movement. There was a detailed process for this in the policy on internal escorting of patients. When a restricted movement was planned, all the wards were informed so that any patients on ground leave would be asked to move to another area to allow a clear route through. This maintained patient dignity as much as possible.
- All staff received training which included the management of actual and potential aggression. Staff practiced relational security and promoted de-escalation techniques to avoid restraints and seclusion where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict.
- We looked at 58 electronic care records across all of the wards. Comprehensive risk assessments were in place for all patients on admission. All patients, where they had wanted to, and had consented to, had been involved in the risk assessment process.
- Risk formulations were good and used structured professional judgement risk assessment schemes, which all staff we spoke to had been trained to use. A structured decision support guide, called HCR-20 was used to assess risk factors for violent behaviour. The structured assessment of protective factors was used to help reduce the risk of any future violent behaviour as well as offering guidance for treatment and risk management plans. The risk of sexual violence protocol was in place and all patients received the short-term assessment of risk and treatability.
- On the older adult ward, Highclere, risk assessments covered patients' mental state, skin condition, oral hygiene, continence, moving and handling and nutrition. Nationally recognised assessment tools were used, where indicated, such as the malnutrition universal screening tool, which is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. The Waterlow score was also used, which gives an estimated risk for the development of a pressure sores. All of this information was reviewed regularly and documented in the electronic care record system. The reviews of risk were part of the multi-disciplinary care review process and the structured professional judgement assessment schemes were recommended good practice by the Department of Health for implementation in forensic and secure setting.
- Wards implemented a 'reducing restrictive practice strategy', which was monitored by a 'reducing restrictive practices forum' held monthly. The programme included developing positive behavioural support plans for every patient, which identified the patients' strengths and difficulties and detailed individualised support interventions to prevent incidents. Staff were trained in verbal de-escalation and how to support patients to change or remove triggers and reinforce coping strategies. The crisis and contingency section of the risk summary contained information that patients had contributed to and participated with the risk assessment and care planning process. All patients were encouraged to have advance directives in place in regards to dealing with incidents which may escalate into violence or aggression. For example, patients had identified their preferred methods for calming down and where appropriate their preferred medicine to be prescribed. Staff had received training on advance directives and positive behaviour support plans.
- Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased in

response to increased risks. The 'Safe ward' initiative was well embedded on all wards. This nationally recognised good practice initiative proposes 10 interventions are used on a ward to reduce conflict and distress for patients and make wards safer places for patients and staff. For example using methods to calm down other than medicine such as listening to music, soft lighting and distraction techniques.

- Staff had developed a 'hot spot team' with the aim of reviewing all patients who had been placed on enhanced observations in excess of 72 hours and developed recommendations to reduce observations. This was discussed and reviewed at the weekly referrals meeting.
- There were blanket restrictions across the eight wards. Restrictions had been thought through with staff and patients before implementation or had a clear rationale. For example, patients admitted to the wards underwent searches to ensure no contraband was brought onto the ward. This was to ensure a safe environment for patients and staff and this had been put in place following incidents of contraband being brought onto the wards. Contraband is an item, which is banned from the ward such as weapons, drugs or alcohol. A list was displayed showing these banned items.
- Staff told us that patient searches were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward or in a private room in the main control room. Staff were trained to carry out searches. Staff told us blanket restrictions were under ongoing review and staff proactively attempted to keep blanket restrictions to a minimum. For example, the patient kitchenette areas on the wards were open for use at all times. Patients were able to purchase technological and electronic equipment as they wished, such as MP3 players, TVs and game consoles. As a direct result of patient feedback and after individual risk assessments, patients were able to have access to their mobile phones and laptops. Patients had to sign a contract to agree to safe usage of these devises.
- The low secure wards and in particular Kingsclere ward, the pre-discharge ward, had negotiated less restrictive environments for their patients. Many patients had their own electronic fobs to gain access in and out of their wards and into permitted communal areas of the hospital, including the dining room and activity areas. Patients were individually risk assessed to be able to prepare their own meals and develop skills to enable a successful discharge into the community. One shared flat was available for five patients and a second shared flat for two patients to live in prior to their discharge into the community. We spoke to patients in the flats who told us they were supported by staff to have autonomy in managing their own lives as independently as possible.
- All of the staff we spoke to knew how to raise a safeguarding concern. Staff said they completed an electronic incident form and informed the nurse in charge or the ward manager. All staff were aware of who the hospital's safeguarding lead was and how to contact them. The safeguarding leads at the local authority were involved in discussions. The safeguarding lead contact details and flow charts of the safeguarding procedure were placed in all of the wards both in the nurses' office and also on the patients' notice boards. All staff had up to date safeguarding. Staff had raised twenty-eight safeguarding alerts across the wards in the preceding year.
- We checked the management of medicines on all of the wards and looked at 95 medicine administration records. There were no recording errors or omissions. On Theale ward, there were several old medicine charts, for some patients, still in the current medicine folder. This could have caused some confusion for the nurse administering as and when required medicine. Staff followed the trust rapid tranquillisation policy for prescribed medicines to be given in an emergency and followed the National Institute for Health and Care Excellence guidance. Staff filled out an electronic incident form every time rapid tranquilisation was used. The incident data, which automatically pulled through onto the 'in charge' dashboard, was monitored by ward managers every day to check the correct protocols had been used. The medical director carried out monthly reviews of rapid tranquilisation usage, which looked at the frequency of rapid tranquilisation administration, the rationale for use, the methods and levels of other interventions made and made recommendations to reduce restrictive practice. All nursing and medical staff had received training in rapid tranquilisation by the hospital pharmacist.
- The medicines were stored securely on all of the eight wards we visited. Daily checks were made of room and refrigerator temperatures to ensure that the medicines

remained suitable for use. Many patients on the low secure wards, Kingsclere ward and the flats were on staged self-medication care plans. All medicines needed were available.

- A pharmacist visited each of the wards weekly. We spoke with the pharmacist and saw evidence of the checks and interventions that they made during their visits, such as checking all patients receiving high dose anti-psychotic medicine had received a physical health check. The pharmacist fed back this information to the nurses and doctors each week and any necessary action had been taken promptly. All the records showed that medicines were frequently reviewed. An electronic medicine management system was in place, which enabled clinicians to be in direct communication with the pharmacist. There was a quarterly medicine management report presented by the pharmacist at every clinical governance meeting as well as the monthly medical advisory committee meeting.
- Patients were provided with information about their medicines. We observed this in a discussion in a multidisciplinary care review. Staff discussed changes to the patients' medicines with them and provided leaflets with more information.
- For any patients wanting to see children from their family the processes and protocols had been put in place to accommodate this. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. Separate and secure family rooms were available away from the ward areas.

Track record on safety

- The provider had reported five serious incidents over the preceding year. Two of these incidents involved expected deaths, one concerned physical assault towards staff, one incident involved self-harm and one incident involved a patient absconsion whilst on Section 17 leave.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to recognise and report incidents on the provider's electronic recording system. The new system had been introduced in April 2017 and automatically populated both the electronic care records and the 'in charge' dashboard with the details of any incidents that had occurred. The ward managers reviewed all incidents daily and forwarded them onto the senior management team. The system ensured that senior managers within the organisation were alerted to incidents in a timely manner and could monitor the investigation and response to these.
- Across the eight wards from 13 April 2017 to 09 October 2017 there had been 603 incidents recorded on the incident management system. The higher reports of incidents across the wards were on Theale ward with 143 incidents and Bucklebury ward with 102 incidents within this timescale. The lowest reported incidents were on Burghclere ward with 21 incidents, Kingsclere with 27 incidents and Headley with 33 incidents.
- The hospital director told us that lessons learnt from incidents were shared at the regular clinical governance meetings at Thornford Park. For example, search protocols were reviewed and changed following contraband being brought into the hospital. A series of serious incident briefings were sent regularly to all wards with details of incidents and learning identified with associated action plans. Thornford Park was also a member of the NHS South of England security group, which was a quarterly meeting of NHS and independent providers where security and safety incidents were shared and discussed. Safety alerts were also shared amongst providers involved in this group.

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. In addition to psychiatrists working as part of the multi-disciplinary teams, general practitioners visited the hospital twice a week to run physical health clinics on site. Care plans were available for those patients with an identified risk associated with their physical health. General practitioners had access to the electronic care records and could input their

contribution directly into the care records. The hospital had a designated and dedicated physical health co-ordinator and physical health meetings were held monthly.

- Care plans were personalised, holistic and recovery focussed. All wards used the care programme approach as the overarching method for planning and evaluating care and treatment. Patients told us they were involved in their care planning process and that the plans were recovery focussed. Staff encouraged patients to be fully involved in planning and evaluating care and treatment.
- The provider used a recovery tool called 'the recovery star'. We looked at some of the care plans co-produced between patients and staff. This initiative encouraged patient engagement and a recovery focussed model of care. The aim of the care plans was to help patients develop their own understanding of their problems and to plan their journey towards recovery. The understanding happened when staff met with patients, to think about their difficulties, strengths and the important events in their life and to share ideas about the patients' journey towards recovery.
- All care plans were stored securely on the electronic recording system and were accessible to all staff as required.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE guidance in the delivery of the therapeutic programme, that included nationally recognised treatments for patients.
- Patients had access to a range of psychological therapies such as cognitive behaviour therapy, occupational therapy, drama and movement therapy, music therapy, art therapy, dialectical behavioural therapy and these were delivered via one to one sessions and in groups. There was evidence of detailed psychological assessments and assessments of neuropsychological functioning. Specific psychological therapy work was available for a variety of offending behaviour. Patients told us therapies had helped to decrease their anxiety and had equipped them to address their issues and journey to recovery. Every one of the 68 care plans we looked at had either a National Institute for Health and Care Excellence (NICE) guidance reference to an identified intervention or another nationally recognised intervention such as from the Quality Network for Forensic Mental Health led by the Royal College of Psychiatrists. The director of clinical services and the hospital director received NICE guidance updates and all relevant changes were highlighted in the monthly clinical governance meetings.
- Staff described how they developed complex physical health care plans. Staff had received training in assessing and effectively managing physical health care needs. Staff supported the integration of mental and physical health and developed comprehensive care plans that covered a range of physical health conditions such as diabetes, cardiac conditions, cancer, incontinence, addictions and breathing problems. General practitioners attended the hospital twice a week and provided physical health care clinics for patients. Regular physical health checks were taking place where needed. We noted a physical health care nurse co-ordinator regularly audited adherence to the required hospital protocol. Regular physical healthcare meetings took place.
- All patients received a yearly physical examination and adherence to this policy was monitored through the monthly medical advisory committee and any deviation from this was highlighted on the 'in charge' dashboard so managers could take action to rectify. The National Early Warning Score (NEWS) had recently been rolled out and an audit tool had been developed to ensure all patients had been assessed. In addition, staff had set up the weight management steering group where staff evaluated and reviewed obesity trends every two months. Staff screened patients in line with the national bowel screening programme, diabetic retinal screening, and abdominal aortic aneurism screening.
- Staff assessed patient's nutrition and hydration needs and developed care plans if needed. Health care assistants had received specific training to enable them to monitor nutritional and hydration needs effectively.

Good

Forensic inpatient/secure wards

- Staff used the recognised rating scales known as the 'health of the nation outcome scale' to assess and record outcomes. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- Staff engaged in clinical and management audits. These included ensuring good physical healthcare for patients, risk assessing ligature risks on the wards, reviewing enhanced observations, ensuring patients had positive behaviour support plans and reducing the use of seclusion and restrictive practices. Staff audited risk assessments and care plans to ensure quality and completion. Regular audits took place, which scrutinised adherence to the forensic service line commissioning for quality and innovation framework (CQUIN). The areas covered included cardio metabolic assessment for patients with schizophrenia, communication with general practitioners, the friends and family test, collaborative risk assessments, carer involvement and pre-admission formulations of need. The provider was a member of the Prescribing Observatory for Mental Health (POMH-UK) which conducts national audits on prescribing for different conditions. Staff participated in this two-year audit timetable.
- A clinical governance bulletin was published monthly and circulated to all wards. The content included updates on patient involvement and experience, health and safety updates, training dates available, recent incidents, staff achievements, best practice examples and service developments.

Skilled staff to deliver care

- Patients had access to a wider multidisciplinary team which included occupational therapists, psychologists, activity co-ordinators, support time recovery workers, social workers, other therapists and pharmacists.
- Staff received appropriate training, supervision and professional development. All staff had updated mandatory training refresher courses recorded. Staff were also encouraged to attend longer internal and external training courses. For example, staff on Highclere ward had received specialist training on dementia and end of life care. Other staff had received training in substance misuse.
- Staff told us the provider's induction programme was detailed, thorough and comprehensive. They found the induction programme particularly helpful in preparing them to provide high quality care for patients and the calibre of the training was exceptional.
- All staff we spoke with said they received individual and group supervision on a regular basis as well as an annual appraisal. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the wards. However, the supervision compliance rate was under the provider's target of 90% at 86%. Managers said this was a recording issue as a new supervision recording system had recently been introduced. Prior to this, the supervision rate was consistently above 90%. Ninety one per cent of all staff had received an appraisal.
- All wards had a regular team meetings and multi-disciplinary team away days and regular managers' workforce development groups took place.
- Senior managers told us they were performance managing a small number of capability issues at the time of our inspection.

Multi-disciplinary and inter-agency team work

- The hospital had fully integrated and adequately staffed multidisciplinary teams throughout the wards. On Highclere ward, for older adults, many nurses were qualified in both mental and physical health care. Regular and fully inclusive team meetings took place. We observed care reviews and clinical hand over meetings on most wards, found these to be highly effective, and inclusive.
- There was an occupational therapy team, which worked across the wards. The team consisted of occupational therapists, a sports therapist, and occupational therapy support staff. A large gym hall was available for patients. An integrated therapy programme was available and included ward based groups such as current affairs, skills development and encouraging emotional expression. Recreational, social & learning groups were available such as the gym and use of the athletics track. Educational, vocational & skills development groups were also available such as food hygiene, literacy and numeracy, job development, mental health and

wellbeing. Additional one to one work and groups were available to address substance misuse issues. Staff also provided drama therapy, emotion management & problem solving.

- We observed inter-agency working taking place, with primary care as a particularly positive example. Patients had access to all secondary care provision. The physical health care nurses carried out long-term condition management, for example for patients with diabetes or cardiac problems. Staff worked closely with the local acute hospital and, in addition had visiting dieticians, podiatrists, physiotherapists, speech and language therapists and specialist tissue viability nurses. Staff maintained strong links with community based treatment teams such as dentists and opticians and encouraged patients to access these in line with the social inclusion programmes.

Adherence to the Mental Health Act and the Code of Practice

- Sixty five per cent of staff had received updated training on the Mental Health Act, including the revised Code of Practice. This is 15% lower than the provider's target of 80%. However, we did not see any adverse impact because of this and staff knew the Mental Health Act, their responsibilities with the application of the Act and patients' rights under the Act.
- We checked some of the files of detained patients on all of the wards and carried out a specific Mental Health Act review on Bucklebury, Hermitage and Burghclere wards to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act and associated Code of Practice and in most cases, this was correct. However, patients were not always reminded of their rights when their circumstances changed, such as on renewal of detention. Staff did not always record what information they had given to patients about their rights. Regular ward audits of Mental Health Act paperwork were carried out and this enabled staff to ensure that the requirements of the Act were being met. Detention papers were available for inspection and were in good order.
- There was evidence that patients had their rights read to them every six months. The Mental Health Act administrator scrutinised all legal paperwork on admission. The nurses in charge of each ward had access to an electronic dashboard, which included Mental Health Act information such as when patients needed reminding of their rights, when consent to treatment status needed reviewing and when periods of detention needed renewing.
- The hospital operated a system for ground leave, within the perimeter fence and for section 17 leave. A consultant psychiatrist may let a patient leave the hospital for a certain period of time, even though they are detained under section. This is called section 17 leave. Each patient had an absent without leave pack prepared. The system for authorising Section 17 leave was thorough and well completed.
- There was active involvement of the independent mental health advocacy service, and information about the service was displayed on information boards in ward communal areas.
- Patients were encouraged to contact the Care Quality Commission if they chose to about issues relating to the Mental Health Act. This was contained in the information folders given to all new patients.
- Except in two cases, assessments of patients' capacity to consent to treatment were available. Both the T2 and T3 certificates were reviewed in line with the provider's policy. These certificates show that patients detained under the Mental Health Act had the proper consent to treatment forms in place.

Good practice in applying the Mental Capacity Act

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy in place. Staff had a good understanding of the MCA although only 64% of staff in the forensic service had updated training which was 16% below the provider's target. All staff in the psychiatric intensive care unit had received Mental Capacity Act training. Staff knew where to get advice regarding MCA, including DoLS, within the hospital. Where required, Deprivation of Liberty Safeguards applications were made.
- There were arrangements in place to monitor adherence to the MCA within the provider.
- For patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions, and patients were given

Good

Forensic inpatient/secure wards

assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the patients' wishes, feelings, culture and history.

- Specialist independent mental capacity advocacy was available to all patients.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We spoke with 80 patients and we received 44 comment cards from patients. The majority of patients we either spoke with or received comment cards from, 75%, made positive comments about their experience of care in Thornford Park. Patients told us they got the help they needed to assist them with their recovery. Patients told us they had been treated with respect and dignity and staff were polite, friendly and willing to help. Patients told us staff were nice and were interested in their wellbeing.
- Patients said staff, whilst very busy, were available for them most of the time. Staff treated patients with compassion and care. Patients told us staff were consistently respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we saw positive interactions between staff and patients. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. Staff showed patience and gave encouragement when supporting patients.
- The staff from the wards received nine compliments in the previous year.
- All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences.
- The last patient satisfaction survey was carried out in June 2017 and 69 patients responded. Of those patients who responded 75% felt that the staff at Thornford Park were caring and supportive. Following the survey, staff developed an action plan which was discussed at the patient council meeting and implemented in July 2017. Action included a revision of the patient information booklet, increasing weekend and evening meaningful activities, introduction of a hip-hop group and the opening of a patient run coffee shop every Saturday.
- Despite the complex, and, at times challenging needs of the patients using the service, the atmosphere on all of the wards was calm and relaxed. We saw a number of swift interactions where staff saw that patients were becoming agitated, distressed or overly stimulated, particularly with visitors on the wards. Staff immediately attended to their patients in a kind and gentle manner.
- We received many commendations by both patients and relatives about individual staff on all of the wards. Comments about them included them being particularly kind and perceptive.
- We spoke to staff who were able to confidently discuss their approach to patients and the model of care practiced across all of the secure wards. They spoke about enabling patients to take responsibility for their care pathways. Staff gave many examples of their strong understanding of and implementation of respectful relational security. They were able to describe situations where de-escalation techniques and a respectful approach had been successful and had promoted reduced usage of restraint and seclusion.

The involvement of people in the care they receive

- Where patients had a planned admission to the wards they had already received information about Thornford Park before admission. The information booklets welcomed patients and gave detailed information about health needs, the multidisciplinary team providing care, treatment options, medicine and physical health needs, treatment options, daily life on the ward, recreation and leisure needs .The booklet orientated patients well to the service and patients we spoke to about the booklet had received a copy and commented on it positively.
- We saw evidence of patient involvement in the care records we looked at, particularly captured in the 'recovery star' documentation on the electronic care

notes. This approach was person centred, individualised and recovery orientated. We also saw that all patients reviewed their care plan once every month with the multi-disciplinary care team and in regular meetings with a member of the ward nursing team.

- During our inspection, we joined a number of multidisciplinary care review meetings on a number of the wards where the views and wishes of the patients were discussed with them. Options for treatment and therapy were given to the patients to consider at all of the meetings. Patients were encouraged to take the role of chairperson at key clinical meetings and that they were given training and support to do this.
- There was evidence of regular audits carried out to ensure all wards were adhering to a person centred approach when care planning with patients.
- There was a scheme in the hospital which provided and trained peer supporters who were existing patients. We met with several peer supporters and they told us about their role which included, for example, acting as buddies for new patients and participating in staff recruitment. The background to this initiative was a national research project, with the national mental health charity, "Together" researching the role of peer support in forensic settings across the UK. Patients contributed to this project and the findings from this piece of work were presented at the International Association of Forensic Mental Health Services conference. In addition, the service was currently involved in a two-year project with the innovation network and Rethink evaluating the benefits of the peer support project.
- The hospital are currently in the process of recruiting peer support workers,ex-patients with lived experience of mental health, into a substantive post within Kingsclere ward..
- The service worked collaboratively with patients to develop a repeated and yearly national service user led conference in the UK. Patients were part of the working group that developed the programme from its concept through to setting up the venue on the day. Patients were encouraged to attend the conference and we met one patient, who was a peer supporter, who had been invited to speak at the conference.
- Information was advertised on all of the wards about local advocacy services available. Fourteen hours of individual advocacy was provided each week. The advocacy service provided three awareness-raising sessions each year, which included care and support advocacy, independent mental health advocacy, independent mental capacity advocacy and NHS complaints advocacy.
- A survey was carried out with family and friends in July 2017. Staff drew up action plans to address issues and concerns raised. The action plans were due to be discussed at a family and friends event in November 2017. Examples of improvements to be made included, carer awareness to be put on the induction training programme for all staff. Staff had introduced the 'triangle of care' best practice approach to working with families and friends of patients. Families, carers and visitors were also given the opportunity to complete a satisfaction questionnaire at the hospital reception.
- Patients had a number of ways of being actively involved in giving feedback about the service and also getting involved in shaping services. For example, each ward held a daily planning meeting and a monthly community meeting which was attended by the patients and representatives from the clinical team and managers. Each ward had set up a, 'you said and we did' initiative. Each ward had a patient representative who attended ward clinical governance meetings to take forward any issues which they wanted addressed. A well-established patients' council met regularly with all patient representatives from each ward. A patient open forum meeting was held four times a year. A patients' forum was available monthly and attended by the senior management team. Recent minutes showed that agenda items discussed included no smoking in the hospital, access to phones, access to laptops and advising on de-cluttering of bedrooms. An ongoing action plan was available addressing such issues as the quality of food, managing smoke free premises, issues with the gym, restrictions, environmental quality, privacy and dignity issues, therapeutic activities and group programme availability and clinical standards. This showed us that patients were encouraged to give feedback on the service they received.
- Patients were trained and encouraged to join the recruitment process to appoint substantive staff.

Good

Forensic inpatient/secure wards

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

Requires improvement

Access and discharge

- Bed occupancy across the eight wards for the preceding six months averaged at 92% and ranged from the lowest of 81% on Theale ward to the highest of 99% on Highclere ward.
- A bed management and referrals meeting was held weekly attended by key clinical and managerial staff and chaired by the hospital director. This meeting oversaw the forensic inpatient and secure care pathway. We noted that in the meeting, all current ward bed occupancy was scrutinised as well as transitions into, through and move on from the service. The bed management meeting monitored and tracked appropriate bed usage and identified any pressures on the system. Key clinical discussions took place at the meeting to enable the entire senior management and clinical team to be aware of updated information. The bed management meeting also monitored all actual and potential inpatient delayed discharges. There were four reported delayed discharges in the preceding six months.
- All patients accepted for transition into, through or from the forensic inpatient care pathway had been assessed and sent a written formulation of what their current needs (and possible future needs) were and how these needs would be met. This was called, 'my initial treatment plan'. Thornford Park had achieved 100% completion with this initiative for all planned admissions.
- We heard from patients who had progressed through the secure care pathway, from being admitted to a medium secure ward at Thornford Park, to living in one of the shared flats on site. Patients told us that they appreciated the opportunity to exercise much more independence, despite still receiving treatment under the Mental Health Act and in many cases being restricted on hospital orders.

The facilities promote recovery, comfort, dignity and confidentiality

- All eight wards had a full range of rooms and equipment available including spaces for therapeutic activities and treatment.
- Quiet rooms were available where patients could meet visitors. Patients had access to multi-faith rooms and a variety of spiritual support.
- All wards with the exception of Highclere ward had access to private pay phone facilities. The pay phone on Highclere ward was not private and was in a communal area of the ward. Patients told us they could ask staff to use a private phone if they wanted to.
- Staff had carried out work on Highclere ward to make the environment easier to navigate for those patients living with dementia. For example, each corridor was painted a different colour. Staff had introduced chalkboards on Theale ward and encouraged the use of art, which had significantly reduced graffiti, on the ward.
- There was direct access to extensive garden areas on all wards and a variety of horticultural endeavour was underway, with garden sheds, flower pots, baskets, herb gardens and vegetable plots, all maintained by patients. All patients were able to enjoy the outside facilities, albeit with staff supervision.
- We had concerns during our previous inspection in 2015 about the poor quality of the food provided and the overall dining room experience. On this inspection, considerable improvements had been made. Patient and staff feedback we received on the quality and range of food was very positive. In the 2017 patient satisfaction survey 63% of responding patients were happy with the quality and choice of food served and only 8% said the food was poor. The dining room experience was a pleasant and enjoyable time for patients and staff. Ward staff joined patients at meal times in the dining room and they interacted well with one another to create a sociable and engaging atmosphere. Snacks and beverages were available over a 24-hour period and patients had access to hot beverages.
- Patients were able to store their possessions securely in their bedrooms. All patients had access to their bedrooms and communal areas of the ward at any time.

Many patients across both the medium and low secure wards had wider access across the hospital site and access in and out of their own ward areas with their own access fob.

- Daily and weekly activities were advertised widely and available on all of the wards. There was a good range of activities and groups available to patients on all of the wards. The activities were varied, recovery focussed and aimed to motivate patients. Staff provided activities in the evenings and across weekend periods. Examples of activities on wards included healthy lifestyle sessions, exercise, cooking, reminiscence and the ageing process, bingo, arts and craft.
- The service had set up the Thornford education academy as part of their recovery college. Staff from Newbury College and the Thornford Park occupational therapy department offered a number of educational courses at the hospital site which enabled patients on hospital restriction orders and with no leave to engage in education pursuit.
- Patients had the opportunity to participate in a range of voluntary work opportunities to learn new skills, knowledge and work experience These included working in housekeeping, the shop, the gym, the patient run café, estates, The Crookham Common Project, grounds maintenance and the Kennett & Avon Canal Trust. We spoke with one patient who was involved in a patient led education programme to teach other patients how to make remote controlled cars. As a direct result of patient feedback, a hip-hop group led by patients had been set up, composing rap songs with positive mental health messages.
- Staff carried out audits to monitor how many hours of activity patients from each ward undertook every week. The target for optimum participation in activities was 25 hours or more each week.

Meeting the needs of all people who use the service

- The provider was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. For example, patients did not always have access to their section 17 leave and activities according to their care plans.
- The staff respected patients' diversity and human rights. All staff had received training on equality and diversity. The provider provided discriminatory incident management forms, which were available around the hospital with collection boxes. The patient advocate led on monitoring these and highlighting any concerns to the senior management team. The local police liaison officer had provided a racial discrimination workshop for patients and staff to increase awareness of the impact of verbal abuse. Attempts were made to meet people's individual needs including cultural, language and religious needs.
- There was a dedicated multi-faith room. A Christian chaplain had recently been appointed and was due to visit the hospital once each week. Links with leaders of other denominations and faiths were made through the chaplain or multi-disciplinary staff. Two patients told us staff facilitated their attendance at a local mosque every week.
- Interpreters were available to staff 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 Mental Health Act were available in different languages.
- We saw up to date and relevant information on the wards detailing information, which included, information on mental health problems and available treatment options, my shared pathway information. In addition, local services available, benefits advice, information on legal and illegal drugs, help-lines, legal advice, advocacy services and how to raise a concern or make a complaint.

Listening to and learning from concerns and complaints

- In the preceding 12 months 31 complaints were received, six were upheld and three were partially upheld. No complaints were referred to the Ombudsman or the independent sector complaints adjudication service.
- Copies of the complaints process were displayed in the wards, communal areas and in the ward information booklets.
- Each ward had a daily planning meeting where patients were encouraged to raise any concerns that they had.

Good

Forensic inpatient/secure wards

When a patient raised a concern; a response about any changes was advertised on the ward to encourage other patients to raise any issues of concern. The yearly patient satisfaction survey outcomes were also made into a poster, for advertising on the wards, and listed the positive action taken by the provider. The system was called, "you said and we did." For example, patients had complained about poor communication and communication had been introduced as a standing agenda item on all ward community meetings. Feedback message slips had been introduced; designated staff had been allocated with the lead responsibility to keep communication boards updated. During our inspection, all of the ward communication boards were up to date, relevant and informative.

- Staff were able to describe the complaints process confidently and how they would handle any complaints.
- All staff had received training on effective complaints prevention and management through the foundation for growth on-line safety module.
- The provider held a 'complaints surgery', an opportunity for patients to have a one to one appointment to listen to their complaint and attempt to resolve it.
- Staff met regularly in the clinical governance meetings both on the ward and across the hospital to discuss learning from complaints. This was being used to inform a programme of improvements, including, improving patients' dietary experience and increasing patient involvement in the care planning process.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Elysium Healthcare took over the management of Thornford Park in January 2017. In March 2017 Elysium Healthcare consulted with its patients, staff, management team and its Board to identify their values. Through this consultation, the organisation's values were agreed as innovation, empowerment, collaboration, compassion and integrity. These values underpinned a vision in which the organisation endeavoured to drive forward standards and outcomes of care in an ethical, open honest and transparent fashion.
- The provider's vision, values and strategies for the service were evident and on display in all of the wards. Staff on the wards considered they understood the vision and direction of the organisation.
- There was evidence of a strong link between the senior team and the provider and oversight of the hospital at board level. Investments had been made into the new electronic systems and capital expenditure to improve the hospital facilities. The ward managers had regular contact with the hospital director, the director of clinical services and the medium secure and low secure services' lead nurses. The senior management and clinical team were visible and we were told by all staff that they often visited the ward. However, several staff said they wanted more face-to-face communication with the senior management team.

Good governance

- Staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised, updated daily and presented in a key performance indicator dashboard, called the 'in charge dashboard'. The unit had good access to robust governance systems, which enabled staff to monitor and manage the ward effectively and provide information to senior staff in the organisation and in a timely manner. One example of this was the dashboard scorecards which was updated daily and covered data including, quality compliance, incident analysis and trends, mandatory training compliance, staff sickness rates and complaints data for the unit. Incidents, care records and workforce data fed directly into the dashboard. Clinical information also fed directly into the dashboard and included data on, patient demographics, legal status of patients, care programme reviews due and carried out, security and risk issues, care reviews due and last carried out, observation levels, escorting baseline risk assessment, room searches, section 17 leave, care plans, meaningful activity, physical health assessments, health of the

nation outcomes and patient forecast discharge date and plan. Staff had successfully implemented three electronic systems over the last six months, including, care records, workforce support and incident reporting.

- We looked at the performance management framework and saw that data was collected regularly. This was presented in the monthly clinical governance meeting, across the hospital and in ward clinical governance meetings. Where performance did not meet the expected standard, action plans were put in place. The unit was meeting set key performance indicators and the information provided was accessible and well advertised.
- Hospital wide and individual ward clinical governance meetings were held monthly and incorporated feedback and discussion, which included clinical effectiveness, patient safety and patient experience.
- The senior management team undertook regular, "quality walk arounds" to the unit. This was introduced to provide real time assurance of practices on the ward. This was part of a supportive framework to encourage high standards and quality improvement. Every month the senior management team met with patients and staff and audited the quality of the environment and the quality of staffing and their communication.
- The hospital had good systems in place to audit incidents, complaints, patients' records and ensure staff appraisals and supervision were occurring and up to date.
- Senior staff had a good understanding of the challenges for the unit staff and were very aware of concerns expressed around low staff numbers. Safe staffing levels were monitored on a shift-by-shift basis using a recognised safe staffing tool.

Leadership, morale and staff engagement

- All of the wards were well-led. There was evidence of clear leadership at a local level. The ward managers were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improving care.
- All staff we spoke with felt able to report incidents, raise concerns and make suggestions for improvements. Staff gave us mixed feedback about how confident they were about being listened to by the senior management team. However, other staff also gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to ward practice. Staff morale therefore was mixed.
- Sickness and absence rates were 7.5%. Managers told us they recognised this figure was high and that they are carrying out more analysis to understand why in order to develop an action plan to try to reduce sickness levels.
- All staff described morale as mixed. We discussed this with managers who said that morale had been adversely affected due to the large organisational change which had taken place over the last year. This change programme had included the introduction of three new electronic recording systems. All staff commented that their team managers were highly visible, approachable and supportive.
- At the time of our inspection, managers told us no grievance procedures were being pursued within the wards and there were no allegations of bullying or harassment.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- All of the wards were accredited members of the Royal College of Psychiatrists quality network for forensic mental health services (medium and low secure services).

Outstanding practice and areas for improvement

Outstanding practice

- There was a scheme in the hospital which provided and trained peer supporters who were existing patients. We met with several peer supporters and they told us about their role which included, for example, acting as buddies for new patients and participating in staff recruitment. The background to this initiative was a national research project, with the national mental health charity, "Together" researching the role of peer support in forensic settings across the UK. Patients contributed to this project and the findings from this piece of work were presented at the International Association of Forensic Mental Health Services conference. In addition, the service was currently involved in a two-year project with the innovation network and Rethink evaluating the benefits of the peer support project.
- Peer support workers, ex-patients with lived experience of mental ill health, were recruited into substantive and paid posts on each of the wards.

The service worked collaboratively with patients to develop a repeated and yearly national service user led conference in the UK. Patients were part of the working group that developed the programme from its concept through to setting up the venue on the day. Patients were encouraged to attend the conference and we met one patient, who was a peer supporter, who had been invited to speak at the conference.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient staff at all times to facilitate all patient leave requirements.

Action the provider SHOULD take to improve

- The provider should ensure that a two-way intercom is installed in the seclusion room.
- The provider should ensure all staff have access to supervision.
- The provider should ensure that the recording of seclusion is recorded in the same format across all wards.
- The provider should ensure all staff have the opportunity to attend training on the Mental Health Act and Mental Capacity Act.
- The provider should ensure all patients are always reminded of their rights when their circumstances changed, such as on renewal of detention.
- The provider should ensure that the old gym equipment is reviewed and where necessary replaced.
- The provider should ensure that staff appraisals for those staff in the psychiatric intensive care unit are up to date.
- The provider should ensure that there is a process in place to highlight delays in transferring patients from the psychiatric intensive care unit back to their home catchment area.
- The provider should continue to build on existing staff recruitment initiatives for the wards and ensure all staff are communicated with directly on this matter.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients as patients did not always have facilitated escorted leave or access to activities according to their care plans. This was a breach of regulation 18(1)