Good

Leicestershire Partnership NHS Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5KF	Herschel Prins Unit Bradgate Mental Health Unit	Phoenix ward	LE3 9DZ
RT5KF	Herschel Prins Unit Bradgate Mental Health Unit	Griffin ward	LE3 9DZ

This report describes our judgement of the quality of care provided within this core service by Leicestershire Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire Partnership NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	Good 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the forensic inpatient/secure services as good because:

- Phoenix ward had clear lines of sight for staff to observe patients. However, Griffin did not. Managers had plans in place to address this issue. However, no time frame was set for the work to be completed. Managers completed ligature audits which highlighted what mitigation was in place to reduce the risk for patients.
- Staff completed comprehensive assessments which included physical health checks and the majority of patients had completed risk assessments. Staff ensured that these were updated regularly.
- Staff used the mental health clustering tool, which included Health of the Nation Outcome Scales (HoNOS) to assess and record severity and outcomes for all patients. Advanced Directives had been introduced to enable patients to make decisions now about their long term care.
- Managers had a recruitment plan in place to increase the number of substantive staff for the service. Managers ensured they used regular bank staff to achieve the required safer staffing levels and to promote continuity of care of patients. 83% of staff received mandatory training. Managers ensured they monitored their staff's compliance with mandatory training using a tracker system. 78% of staff had completed their annual appraisal. Managers ensured they monitored the reporting and recording of incidents and complaints. They provided feedback to staff via monthly ward meetings, MDT meetings supervision and handovers.
- Patients gave positive feedback regarding the care they received. Patients were able to access hot and cold drinks any time during the day. Patients could approach staff at night to request them. Staff interacted with patients in a caring and respectful manner. Staff we spoke with demonstrated their dedication to providing high quality patient care.
- Wards had well equipped clinic rooms with appropriate equipment which staff regularly checked.
- The average bed occupancy was low. The service did not have any out of area placements, readmissions or delayed discharges. Staff worked with both internal and external agencies to coordinate care and discharge plans.
- The trust had a range of information displayed on the ward and the hospital site relating to activities, treatment, safeguarding, patients' rights and complaint information.

However:

- The service had seven vacancies for qualified nurses and three for non-registered nurses.
- There was a blanket restriction. On Phoenix ward patients were not allowed access to the garden. However, this was a temporary restriction due to the building works and patient safety.
- Clinical supervision rates were low. 42% of staff on Phoenix ward and 27% Griffin ward had received clinical supervision. Managers did not ensure that the staff were receiving regular clinical supervision and had not met the trust target compliance rate of 85%. Staff morale on Griffin ward was low due to the announcement of the ward's closure upon the completion of works on Phoenix ward.
- Staff explained to patients their rights under the Mental Health Act on admission and routinely thereafter, although we saw this was not always documented in the patients' care notes.
- Clinic rooms were overstocked with medications. Nursing staff did not have a stock list to randomly check medication which meant they could not reconciliation check.
- The phones on each ward were in communal areas; the phone on Griffin ward had not been moved since the last inspection, although it had a privacy hood installed. There was a mobile phone in the ward office that patients could use for private calls, for example to a solicitor.
- Patient views on the quality of the food were variable.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Griffin ward had clear lines of sight for staff to observe patients. However, Phoenix did not. Managers had plans in place to address this issue. However, no time frame was set for the work to be completed.
- Managers completed ligature audits which highlighted what mitigation was in place to reduce the risk for patients.
- Staff completed the majority of risk assessments for patients and updated these regularly.
- The service complied with same sex accommodation guidance.
- Wards had well equipped clinic rooms with appropriate equipment which staff regularly checked.
- The seclusion room on Griffin ward met the required standard as outlinedin the Mental Health Act Code of Practice. Data supplied by the trust showed there were no instances of seclusion, segregation or restraint.
- Managers ensured they used regular bank staff to achieve the required safer staffing levels and to promote continuity of care of patients.
- 83% of staff received mandatory training. 85% of staff was compliant with safeguarding vulnerable adults training. Patient activities which included escorted leave were rarely cancelled due to low staff numbers.
- Incidents were reported via an electronic incident reporting form. Staff we spoke with knew how to report incidents using the electronic reporting system.

However:

- The service had seven vacancies for qualified nurses and three for non-registered nurses.
- There was a blanket restriction. On Phoenix ward patients were not allowed access to the garden. However, this was a temporary restriction due to the building works and patient safety.
- Clinic rooms were overstocked with medications. Nursing staff did not have a stock list to randomly check medication which meant they could not reconciliation check.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Clinical supervision rates were low. 42% of staff on Phoenix ward and 27% Griffin ward had received clinical supervision.

Summary of findings

- Staff explained to patients their rights under the Mental Health Act on admission and routinely thereafter, although we saw this was not always documented in the patient's care notes.

However:

- Staff completed comprehensive assessments which included physical health checks for all patients which they completed in a timely manner.
- Patients had access to psychological therapies, recommended by the National Institute for Health and Care Excellence for example cognitive behavioural therapy.
- Staff used the mental health clustering tool, which included Health of the Nation Outcome Scales to assess and record severity and outcomes for all patients.
- 78% of staff had completed their annual appraisal.
- Staff worked with both internal and external agencies to coordinate care and discharge plans.

Are services caring?

Good

We rated caring as good because:

- Patients gave positive feedback regarding the care they received.
- Staff interacted with patients in a caring and respectful manner.
- An external consultant supported patients in daily community meetings.
- My shared pathway booklets to involve patients in their care had been introduced.
- Advanced Directives had been introduced to enable patients to make decisions now about their long term care.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The average bed occupancy was low. The service did not have any out of area placements, readmissions or delayed discharges.
- Patients had lockable facilities for the safe storage of their personal possessions.
- Patients were able to access hot and cold drinks any time during the day. Patients could approach staff at night to request them.
- The trust had a range of information displayed on the ward and the hospital site relating to activities, treatment, safeguarding, patients' rights and complaint information. There were leaflets in other languages and interpreters available when required.

Summary of findings

- Both wards were on the ground floor with full disabled access.
- Staff supported patients to make complaints if required. In the last 12 months there had been no complaints made.

However:

- The phones on each ward were in communal areas; the phone on Griffin ward had not been moved since the last inspection, although it had a privacy hood installed. There was a mobile phone in the ward office that patients could use for private calls, for example to a solicitor.
- Patient views on the quality of the food were variable.

Are services well-led?

Good

We rated well led as good because:

- Some staff we spoke with knew the trust's vision and values and who the senior managers were.
- Managers ensured they monitored their staff's compliance with mandatory training using a tracker system.
- Managers ensured they monitored the reporting and recording incidents and complaints. The provided feedback to staff via monthly ward meetings, MDT meetings supervision and handovers.
- Managers had a recruitment plan in place to increase the number of substantive staff for the service.
- Managers had access to key performance indicators to gauge the performance of the team.
- Staff we spoke with demonstrated their dedication to providing high quality patient care.
- Staff on Phoenix ward told us of their cohesive team working, and how they felt they were well supported by each other.

However:

- Managers did not ensure that the staff were receiving regular clinical supervision and had not met the trust target compliance rate of 85%.
- Staff morale on Griffin ward was low due to the announcement of the ward's closure upon the completion of works on Phoenix ward.

Summary of findings

Information about the service

The Herschel Prins Unit comprised Phoenix with 12 male beds and Griffin ward with six female beds low secure wards for men. Griffin ward had closed earlier in the year for renovation works. The female patients were discharged or transferred to similar units elsewhere. The ward reopened in May 2016. At the time of our inspection it was being used as a male only ward for patients who would ordinarily be allocated to Phoenix ward. This was to allow similar renovation work to be completed safely on Phoenix ward while its beds were half full. When the works are completed, patients currently allocated to Griffin ward will transfer to Phoenix ward.

The service was last inspected in March 2015 and was rated overall as 'requires improvement' due to the following:

- Ligature risks had been identified in bedrooms, bathrooms and toilets but there was no clear action to address all of the identified risks.
- The seclusion rooms had known blind spots but no action had been taken to reduce them.
- Care plans and risk assessments did not show staff how to support patients. Staff were inconsistent in updating the Historical Clinical Risk Management (HCR-20) assessments.
- Staff did not demonstrate a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA). Patients' capacity to consent to their treatment had not been assessed in some cases.
- The telephone for patients' use was situated in communal areas and did not provide patients with sufficient privacy.
- We identified that staff did not always take a person centred approach to care and did not always take positive risks when this might have been indicated. The forensic services staff said they felt lost and did not know where they were going strategically.

Our inspection team

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, head of hospital Inspection (mental health), CQC

Inspection Manager: Sarah Duncanson, inspection manager (mental health), CQC

The team that inspected the forensic inpatient/secure wards consisted of two inspectors, three specialist advisors and an expert by experience.

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced in sharing their experiences and perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and trust:

- Is it safe?
- Is it effective?

Summary of findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, and asked stakeholders for information.

During the inspection visit, the inspection team:

- visited the two wards at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the team leader
- spoke with the manager for both of the wards
- spoke with the deputy ward manager/matron on both wards
- spoke with 18 other staff members, including doctors, nurses, a ward clerk, a psychologist and an occupational therapist
- reviewed six treatment records of patients
- carried out a specific check of the medication management on the wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients told us they felt safe in their environment due to good staff training. They were treated with respect, had their needs responded to, were involved in their care planning and spent time with staff.
- Patients told us of concerns over privacy, as staff sat in on all visits. Phone calls could be overheard on the ward phone. However, private calls could be made using the office phone.
- Staff engaged well with patients, and were generally visible.
- There were not always enough members of staff to enable occupational therapy interventions as they had to have another member of staff present due to training issues. Although there were activities every day that were relevant to their needs.
- Patients told us there were generally enough staff, but most were bank or agency staff.
- Patients told us there were issues with the heat on the wards and with hot and cold water.
- Patients reported that meals were of good quality and variety, and they catered to different cultures and religious beliefs.
- Patients told us they have regular daily physical health checks.

Good practice

- The EssenCES survey had been introduced. This was a short questionnaire described as "an economic and valid instrument for assessing the ward atmosphere in forensic psychiatry" to measure patient outcomes.
- Advance directives had been introduced in the forensic service and they were observed in patient notes. An advanced directive "is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity".
- There was an independent external consultant providing support to patients in community meetings.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff receive regular supervision and have a robust system to record staff's compliance.
- The trust must ensure that staff record in patient notes the informing of patients' rights under Section 132 of the Mental Health Act.

Action the provider SHOULD take to improve

- The trust should ensure that medication is not over stocked on wards.

Leicestershire Partnership NHS Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Phoenix ward	Herschel Prins Unit Bradgate Mental Health Unit
Griffin ward	Herschel Prins Unit Bradgate Mental Health Unit

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 Trust.

- Staff completed mandatory training in the Mental Health Act (MHA) with three yearly refreshers. Overall compliance for staff was 80%, which is in line with the trust standard.
- Staff completed consent to treatment and capacity assessments for patients. The relevant paperwork (T2 and T3 forms) were attached to medication charts for staff reference.
- The Mental Health Act administration team completed annual audits to ensure that the Mental Health Act was being applied correctly.
- Administrative support and legal advice on implementation of the Mental Health Act Code of Practice was available to staff from a central team.
- Patients could access the independent mental health advocate (IMHA). An independent advocate is specially trained to support people to understand their rights under the Mental Health Act and participate in decisions about their care and treatment.
- We looked at six paper care records and cross referenced these with the electronic recording system. The documentation was in order.
- We saw recording in patients' notes of awareness and discussion of Section 17 Mental Health Act leave plan and conditions.
- Staff we spoke with told us they explained to patients their legal rights under the Mental Health Act on admission and routinely thereafter, although this was not always recorded in patient notes.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed mandatory training in the Mental Capacity Act 2005 (MCA), which included Deprivation of Liberty Safeguards information for staff reference, with three yearly refreshers. Overall compliance for staff training was 91**%.** This is approximately eight per cent above the trust target.
- There were no patients subject to Deprivation of Liberty Safeguards at the time of inspection.
- Registered staff were trained in and had a good understanding of MCA 2005.
- Non-registered staff we spoke to said they were not involved in Mental Capacity Act assessments or Deprivation of Liberty Safeguards applications so had little knowledge of them.
- The trust had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards, which staff were aware of and could refer to if needed.
- We saw evidence that staff recorded capacity assessments in patients' care records for people who might have impaired capacity.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty Safeguards, within the trust.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- There were clear lines of site on both wards, apart from where Phoenix ward had a bookcase fixed to the wall in a blind spot that did not have a mirror to enable it to be observed from the ward office. Staff told us that this had been raised and the bookcase was due to be dismantled along with the other renovation work taking place, but could not give a specific timeline.
- Managers completed ligature audits. A ligature risk is a fixed item to which a patient might tie something for the purpose of self-strangulation. The audit did not identify all risks. However, the audit highlighted how identified risks were mitigated by staff.
- Both wards were male only wards and therefore complied with same sex accommodation guidance.
- Wards had well equipped clinic rooms with appropriate equipment. Staff completed regular checks on all equipment and kept accurate records.
- The seclusion room on Griffin ward met the required standard as outlined in the Mental Health Act Code of Practice.
- The wards were clean and tidy. Griffin ward was maintained to a good standard and Phoenix ward was in the process of renovation. Furnishings were well maintained, comfortable and suitable for the environment.
- The trust provided data that showed the patient-led assessments of the care environment (PLACE) compliance was 97% for cleanliness. PLACE assessments focus on different aspects of the environment in which care is provided.
- We saw that all staff adhered to infection control principles including handwashing.
- Cleaning took place during our visit and rotas were displayed. Ward staff undertook daily environmental checks.
- Most patients told us that the bathroom, toilet and kitchen arears were always clean, and they felt that the furnishings and fittings were well maintained. Clean stickers were observed to be visible and in date.
- Staff had personal alarms across all wards. Reception staff issued personal alarms to visitors to ensure safety. In addition to this staff used radios to summons help if required. Staff told us there was only one on Phoenix ward when there should be four. The trust provided information that capital monies had been secured to replace the radios and network.

Safe staffing

- The trust supplied data relating to their staffing establishment. The data showed the total establishment of registered nurses whole time equivalent (WTE) was 21.8. At the time of the inspection, there were seven vacancies. The total establishment for non-registered nursing assistants was 23. The service has three vacancies.
- There was an active recruitment plan for Griffin ward who recruited eight nurses in July 2016. Phoenix ward had an increase from six to nine nurses.
- Staff told us that the daily rotas comprised of two registered and four non-registered nurses for early and late shifts and one registered and three non-registered nurses for night shifts. The ward manager is able to adjust staffing levels daily to take account case mix. We did not see a registered nurse in the patient areas at all times.
- Between June 2016 and August 2016 bank staff had covered 429 shifts and agency staff covered 64 shifts due to sickness, absence or vacancies. However, 43 shifts had not been covered, which resulted in wards working below the numbers required to meet the needs of the patients.
- Managers ensure that they used regular bank staff to cover shift vacancies where possible, to promote continuity of care of patients. The majority vacancies were due to long term sickness or maternity leave that had not been backfilled.

Good

Are services safe?

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

- Data provided showed no substantive staff leavers in 12 month period to August 2016.
- Staff told us that activities are not cancelled due to low staff numbers, and escorted leave is rarely cancelled.
- Two consultant psychiatrists covered both wards, there was one vacant post. Staff told us they could easily access medical input during the day. Access to doctors out of hours was via doctors on call.
- Trusts are required to submit monthly safe staffing reports to ensure patient safety. An average 70% fill rate for January 2016 would mean that only 70% of the planned working hours for daytime working staff were filled.Data provided showed that both wards were over 125% each month except for night nursing staff where it was approximately 100%.
- 83% of staff had completed mandatory training. However, only 61% of staff had completed training in adult immediate life support and 74% for Mental Health Act training.

Assessing and managing risk to patients and staff

- Data supplied by the trust showed for the period 1 February 2016 to 31 July 2016 there were no instances of seclusion, segregation or restraint. However, we saw one restraint form that was not fully completed; staff acknowledged this.
- The trust had a seclusion policy on the intranet for staff reference, which had been updated to include changes to the Mental Health Act Code of Practice. Seclusion refers to the supervised confinement of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance, which is likely to cause harm to others (Mental Health Act Code of Practice 26.103).
- Staff completed comprehensive risk assessments for patients and updated these regularly. We reviewed six patient care records and found one that did not have an updated risk assessment following an unauthorised leave.
- Staff completed a nationally recognised risk assessment tool, for example the historical clinical risk management tool (HCR20).
- Managers reported that restrictive practices had been reduced since the last inspection, for example the blanket searching of all patients on return from leave had stopped. However, there was a blanket restriction on access to the garden on Phoenix ward, this was a temporary restriction due to the building works and patient safety.
- 85% of staff were compliant with safeguarding vulnerable adults training. Staff we spoke with were able to explain the safeguarding process and understood their responsibilities to report any safeguarding concerns.
- Medicines were stored securely and in accordance with the provider policy and manufacturers' guidelines. We reviewed all medication administration records (MAR) and found no errors, omissions or missing nurse signatures when the medication had been administered. However, both clinic rooms were overstocked with some medications for example on Griffin ward there were 112 Haloperidol, 144 Lorazepam and 220 Movicol sachets. Nursing staff did not have a stock list to randomly check medication so could not complete a reconciliation check.
- A family room in reception was used to allow for children to visit family members away from the ward.

Track record on safety

- Between 1 July 2015 and 30 June 2016 there was one serious incident reported for Phoenix ward which had been investigated. Managers shared the outcome and lesson learnt from this investigation to ensure staff made changes to practice on the ward to minimise the risk of the same incident occurring.

Reporting incidents and learning from when things go wrong

- Incidents were reported via an electronic incident reporting form. Staff we spoke with knew how to report incidents using the electronic reporting system.
- Staff told us that incidents were discussed in handovers and at team meetings.Some staff told us they had access to debriefs and support following incidents.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Staff completed comprehensive assessments for all patients which they completed in a timely manner. We reviewed six care plans and they were all up to date, personalised, holistic and recovery orientated.
- Staff completed physical health assessment checks for patients on admission. Staff provided appropriate ongoing physical health checks when appropriate.
- All information needed to deliver care was stored on an electronic system which all staff had access to.

Best practice in treatment and care

- Staff followed National Institute for Clinical Excellence (NICE) guidance when medication was prescribed.
- Patients had access to psychological therapies, recommended by the National Institute for Health and Care Excellence (NICE) for example cognitive behavioural therapy (CBT).
- Staff used the mental health clustering tool, which included Health of the Nation Outcome Scales (HoNOS) to assess and record severity and outcomes for all patients.
- We saw evidence of staff contributing to clinical audits, for example record keeping audits.

Skilled staff to deliver care

- The team consisted of nurse, occupational therapists, doctors, health care assistant and psychologists and social worker.
- The staff we spoke with were experienced and qualified to carry out their duties.
- Psychology had started a fortnightly training programme for all disciplines. For example CBT, assertiveness and least restrictive practice.
- Clinical supervision rates between 01August 2015 to 31 July 2016 were 42% for Phoenix ward and 27% for Griffin ward. This fell below the trust target of 85%. We reviewed the supervision records and found that staff had not completed these fully.
- The appraisal rate to non-medical staff within this service was 78%. This was 5% lower than the trust average for appraisals.

Multi-disciplinary and inter-agency team work

- There were weekly multidisciplinary team meetings. Patients attended this on alternating weeks.
- Staff completed handovers at the start of each shift to share information about risk issues, discussed staffing levels and specific nursing duties that needed to be carried out during the shift.
- Staff worked with both internal and external agencies including local authorities, ministry of justice, police the multi-agency public protection arrangements (MAPPA), and the integrated offender management (IOM).
- Staff told us that they worked closely with the community forensic team to coordinate care to support with discharges.

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

- Patients receiving care and treatment at the time of inspection were detained under the Mental Health Act 1983 (MHA).
- 80% of staff had been training in the Mental Health Act and Mental Health Code of Practice.
- Staff completed consent to treatment and capacity assessments for patients. The relevant paperwork (T2 and T3 forms) were attached to medication charts for staff reference.
- The Mental Health Act administration team completed annual audits to ensure that the Mental Health Act was being applied correctly.
- We looked at three sets of detention paperwork and cross referenced these with the electronic recording system. The documentation appeared to be in order.
- Administrative support and legal advice on implementation of the Mental Health Act Code of Practice was available to staff from a central team.
- Patients could access the independent mental health advocate.An independent advocate is specially trained to support people to understand their rights under the Mental Health Act and participate in decisions about their care and treatment.

Are services effective?

Requires improvement

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

- Staff we spoke with told us they explained to patients their rights under the Mental Health Act on admission and routinely thereafter, although we saw this was not always documented in the patient's care notes.

Good practice in applying the Mental Capacity Act

- 91% of staff completed training in the Mental Capacity Act, which included Deprivation of Liberty Safeguards.
- There were no patients subject to Deprivation of Liberty Safeguards at the time of inspection.
- The trust had a policy on Mental Capacity Act that included Deprivation of Liberty Safeguards, which staff were aware of and could refer to if needed.
- We saw evidence that staff recorded capacity assessments in patients' care records for people who might have impaired capacity.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty Safeguards, within the trust.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed positive and helpful interactions between staff and patients.
- Patients we spoke with gave positive feedback regarding their care and the approach used by the staff.
- Patients told us that staff treated them with respect and dignity.
- We observed staff interacting in physical activities with the patients on Phoenix ward. For example table tennis.
- We observed staff treating patients with respect and dignity. For example knocking on patients' bedroom doors and standing to one side while waiting for them to answer.
- 'Tell the matron' boxes were available for patients to make confidential comments. Although these were located in the ward offices, staff would take them to the door for the patients to deposit their comments. However, staff told us there was a lack of response from patients.

The involvement of people in the care that they receive

- There was an admission process and introduction to the ward. This included an information pack and information on a patient's rights to inform and orientate patients to the ward.
- It was not always recorded in the patient care notes that they had been involved in their care plan.
- The use of 'my shared pathway' had been introduced to the forensic service to involve patients in their care, although staff had not yet fully embedded it into practice.
- Patients told us they have the opportunity to give feedback about the service or make complaints.
- Patients had regular access to advocacy services on the ward and could also request it.
- We saw minutes of daily community meetings where patients could raise issues, and there was an independent external consultant providing support to them.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The average bed occupancy from August 2015 until July 2016 for Griffin ward was 69% and Phoenix ward 57%. This meant patients had access to beds when they returned from leave and beds available to people living in the catchment area when needed.
- Between August 2015 and July 2016 the length of stay ranged from 248 days to 426 days.
- The service did not have any out of area placements between 01 February 2016 and 31 July 2016.
- Data provided showed there were no readmissions or delayed discharges to forensic services between August 2015 and July 2016.
- We were told that there was a monthly low secure panel meeting of the multidisciplinary team and commissioners where admissions and discharges were discussed.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust was undertaking refurbishment on Phoenix ward so there were limited rooms for the patients to participate in therapeutic activities. Drinks were being served from a temporary table in the corridor area.
- Patient views on the quality of the food were variable. The trust had received a Food Standards Agency maximum rating of five for food hygiene in all food preparation areas.
- The phones on each ward were in communal areas; the phone on Griffin ward had not been moved since the last inspection, although it had a privacy hood installed. There was a mobile phone in the ward office that patients could use for private calls, for example to a solicitor.
- Patients had lockable facilities for the safe storage of their personal possessions.
- Patients were able to access hot and cold drinks any time during the day. Patients could approach staff at night to request them.
- Both wards had bedrooms with en-suite facilities with showers.There were bathrooms in both wards, although the Phoenix bathroom was out of order at the time of inspection.Staff could not tell us how long this had been out of order, but that it had been reported and was waiting for maintenance to make repairs.

Meeting the needs of all people who use the service

- The trust had a range of information displayed on the ward and the hospital site relating to activities, treatment, safeguarding, patients' rights and complaint information.
- Both wards were on the ground floor with full disabled access.
- There were leaflets in other languages available when required.Staff were able to access interpreters to assist communication with patients, as needed.
- There was a multi faith room, which could be accessed on the Herschel Prins site and local representatives of a range of faiths and beliefs would visit when requested so patients could access spiritual support.

Listening to and learning from concerns and complaints

- Data provided showed there were no complaints received for Phoenix ward or Griffin ward from August 2015 to July 2016.
- Staff told us that patients were helped to make and write complaints where appropriate and staff assisted patients with the complaints process as needed. Information on how to make a complaint was available on the wards. Staff told us verbal complaints were dealt with on a local level and usually recorded in the electronic patient notes. There were two recent verbal complaints, one was withdrawn and the second about heating was being investigated.
- Team meeting minutes showed that staff were told feedback about complaints from reflective practice, team meetings and emails. We were shown team meeting minutes of various dates.

Are services well-led?

Good

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

Our findings

Vision and values

- Some staff we spoke with knew the trust's vision and values.
- Most staff knew who the most senior managers were but were unaware if they visit the wards.
- Staff we spoke with knew who their immediate senior managers were, but told us they did not see them on the wards.

Good governance

- The ward manager had sufficient authority and administrative support to carry out their role.
- Managers ensured they monitored their staffs' compliance with mandatory training using a tracker system. This highlighted when managers needed to book training for staff to ensure that staff remained up to date with mandatory training.
- Managers ensured they monitored the reporting and recording of incidents and complaints. They provided feedback to staff via monthly ward meetings, MDT meetings supervision and handovers.
- Whilst there were systems in place for staff to record clinical supervision this was not being completed. Managers did not ensure that the staff were receiving regular clinical supervision and has not met the trust target compliance rate of 85%.
- Managers had a recruitment plan in place to increase the number of substantive staff for the service.
- The majority of shifts were covered by a sufficient number of staff of the right grade and experience. If bank or agency staff were required managers booked staff that were familiar to the ward.
- Managers had access to key performance indicators to gauge the performance of the team.

Leadership, morale and staff engagement

- Staff we spoke with demonstrated their dedication to providing high quality patient care. Some of the medical team felt that as a responsible clinician, they could contribute to operational management but have little strategic influence.
- Staff knew how to use the whistle-blowing process and felt that they were able to raise concerns if needed without fear of victimisation.
- Staff on Phoenix ward told us of their cohesive team working, and how they felt they were well supported by each other.
- Staff morale on Griffin ward was extremely low due to the announcement of the ward's closure upon the completion of works on Phoenix ward in early December 2016. Staffs' concerns included dissatisfaction with how the trust had communicated the closure to them and lack of consultation, as not all staff were directly informed of this by their managers. The trust confirmed to us the ward was temporarily closed, whilst it reviewed the low secure contract with commissioners, and considered other options for the longer term functionality of the unit. The current staff survey was not complete at the time of inspection as it was currently being undertaken.

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 9 HSCA (RA) Regulations 2014 Person-centred care • Patient's Section 132 rights were not being explained to them or documented. This was a breach of Regulation 9

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 trust had not ensured that all staff were in receipt of supervision This was a breach of Regulation 18