

Good 

North East London NHS Foundation 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)
RATY1	Sunflowers Court	Morris Ward	IG3 8XJ

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Outstanding 

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 ward as good because:

- The environment was clean and well maintained. The clinic room was well stocked and maintained, with emergency medical equipment checked daily.
- All the patients on the ward told us they felt safe and that their possessions were secure. Risk assessments were thorough, up to date and agreed with individual patients.
- There were appropriately qualified and trained staff on the ward at all times. There was good multi-disciplinary working across the team with a variety of mental health professions included. Staff regularly received supervision and appraisals. Levels of staffing were adjusted to the acuity of need on the ward.
- Psychological assessment and treatments were readily available on the ward. The service offered a three month psychological follow up after discharge to prevent readmissions to the service which was not funded or commissioned for.
- All staff had a good understanding of the Mental Health Act and Mental Capacity Act and maintained good documentation relating to the Acts.

- Staff were caring, supportive and respectful of patients and their recovery. Care plans were contemporaneous, personalised and demonstrated clear evidence of patient involvement. Staff facilitated family involvement groups to promote family and carers participation with patient recovery. The team's dedication to involving patients in activities and therapeutic activities in the community was good. The service had good links with a local professional football club, a local horticultural activity centre and the local college.

However:

- An incident occurred a week before the inspection and an incident form had not yet been completed at the time of the inspection. A serious incident update form has since been completed and lessons were learned from the incident.
- Mental Health Act original documentation was archived. Only the renewal papers were available on the ward which meant that staff could not follow the chronology of various documents related to the detention of patients immediately on the ward.
- The advocacy services did not hold a dedicated, regular drop in clinic for patients.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Ligature risk audits and environmental risk assessments were in place and updated regularly.
- All patients on the ward told us they felt safe and their possessions were secure.
- Staff attempted to proactively engage with patients to reduce the use of restraint and seclusion.
- Patients' risk assessments were robust and consistent with clear evidence of mutual agreements with the patient regarding risk.
- There was sufficient suitably qualified and trained staff on the ward.
- The ward would actively adjust its daily staffing levels to reflect the acuity of need on the ward.
- The clinic room was well stocked and emergency medical equipment checked daily.
- The ward was well maintained and clean throughout.

However:

- One recent incident had not been completed on an incident form at the time of the inspection. A serious incident update form had since been completed and lessons were learned.

Good



Are services effective?

We rated effective as good because:

- The assessment of patient needs and their care planning was thorough, personalised and holistic with a strong focus on recovery.
- Staff had a good understanding of the Mental Health Act 1983 and the Mental Capacity Act Code of Practices and there was clear documentation of their use.
- There was good multi-disciplinary working across the team using a variety of mental health professionals.
- Supervision occurred regularly and appraisals were up to date.
- Psychological assessments and treatments were readily available on the ward.

However:

Good



Summary of findings

- Mental Health Act original documentation was archived. Only renewal papers were readily available on the ward which meant that staff could not follow the chronology of various documents related to the detention of patients immediately on the ward.

Are services caring?

We rated caring as good because:

- Patients informed us that all staff were caring, respectful and supportive of their recovery.
- Family therapeutic work was actively encouraged and promoted on the ward.
- There was strong evidence of patients engaging with their treatment and care through daily morning 'mutual help' meetings and chairing regular community meetings.

However:

- The advocacy services did not hold a dedicated, regular drop in clinic for patients.

Good



Are services responsive to people's needs?

We rated responsive as outstanding because:

- The ward had excellent links with a local professional football team with their programme 'coping through football'. Patients could train with the team twice a week and attend weekend matches at no cost.
- The ward held its own 'horticultural club' and had a dedicated garden with raised beds for patients to grow their own vegetables. This club regularly visited a local farming centre to further improve the patient's knowledge and skills in this area.
- Patients were able to enrol at the local college to gain formal qualifications and new skills to support reintegration into the community.
- The service offered a three month follow up with a psychologist after discharge to prevent readmissions to the service. This work was not funded or commissioned for and demonstrated the commitment to supporting patients with their recovery.
- The ward had good activity rooms, multi faith room and gym for patients to use.

Outstanding



Are services well-led?

We rated well-led as good because:

- There was high morale and pride amongst all staff working for the service.

Good



Summary of findings

- Staff were aware of the visions and values of the trust and these were well mapped against local objectives and targets.
- The ward was participating in the 'safe wards' initiative and held membership with the Quality Network for Forensic Mental Health Services.
- Clinical audits were regularly undertaken on the ward and learning from these fed back to all staff.

Summary of findings

Information about the service

The forensic service for North East London NHS Foundation Trust is provided in Morris Ward at Sunflowers Court on the Goodmayes hospital site. The service provides low secure services for up to 15 men in a purpose built location since its inception in 2011.

Morris Ward accepts male patients from the Barking & Dagenham, Havering, Redbridge and Waltham Forest catchment areas.

The ward had received no previous CQC inspections and last received an unannounced Mental Health Act review inspection on 21 October 2014.

Our inspection team

Chair: Helen Mackenzie, Director of Nursing, Berkshire Healthcare NHS Foundation Trust

Head of Inspection: Natasha Sloman, Head of Hospital Inspections, Care Quality Commission

Team Leader: Louise Phillips, Inspection manager, Care Quality Commission

The team that inspected the forensic inpatient/secure service comprised an inspection manager, an assistant inspector, two specialist advisors with nursing experience and an expert by experience.

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 provider:

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited the one forensic ward at the Goodmayes hospital site and looked at the quality of the ward environment.
- Observed how staff were caring for patients.
- Spoke with four patients who were using the service.
- Spoke with the manager and deputy manager for the ward.
- Spoke with six other staff members; including a doctor, nurses, psychologist and social worker.
- Attended and observed a hand-over meeting.
- Reviewed six patient care records.
- Carried out a specific check of the medicine management on the ward and checked all 15 patient medicine cards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

The patients we spoke to were very complimentary about the service and the positive role of staff in their recovery. Patients told us they were actively involved in the planning of their care. The patients felt their voices were heard through a range of different ways including

morning 'mutual help' meetings, regular community meeting and the complaints process. Patients said the ward areas were always clean and tidy and they felt very safe on the ward.

Good practice

- The service had excellent links with external organisations to aid in patient recovery. The wards programme 'coping through football' allowed some patients to train with professional footballers at a local club and received tickets to weekend matches at no cost.
- The 'horticultural club' on the ward would visit a local farming centre to extend patients knowledge and skills in this field.
- Links with the local college allowed patients to gain valuable skills and formal qualifications to aid reintegration into the community and this education was fully encouraged by members of staff on the ward.
- The ward was dedicated to providing a three month post discharge service for patients to prevent readmissions and this work was not funded or commissioned for.

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **SHOULD** take to improve

- The trust should consider inviting advocacy services to hold dedicated, regular drop in clinics for patients.
- The trust should consider a plan of action to ensure staff receive training on the Mental Health Act.

North East London NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Morris Ward	Sunflowers Court

Mental Health Act responsibilities

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

We checked the files available on Morris ward and found that Mental Health Act documentation was up to date and renewal papers were available. However, original detention papers were archived and not readily available to staff on the ward. This meant that staff could not follow the chronology of various documents related to the detention of patients immediately on the ward. We were told that original MHA section papers could be retrieved from the MHA office as necessary during working hours. Arrangements were in place so that the bleep holder could access MHA records out of hours if necessary.

The trust could demonstrate appropriate policies were in place to ensure the operations of the Mental Health Act met the standards of the Code of Practice.

Staff documented where they were routinely reading section 132 rights to patients.

Section 17 leave of absence forms were appropriately completed and patients were unable to leave the ward without agreeing and signing the conditions of their leave.

Patients negotiated their leave times with staff and fellow patients during community meetings and morning 'mutual help' meetings. Where leave was cancelled due to staffing shortages, the ward staff would endeavour to move it to another time slot as agreed with by the patient.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of the inspection, 93% of staff were up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. All patients on the ward

Detailed findings

were detained under the Mental Health Act and no Deprivation of Liberty Safeguards applications had been made. No patients we reviewed on the ward required such an application.

The ward undertook mental capacity assessments following the code of practice and documentation of its use was consistent and thorough. Where a patient lacked capacity, we saw evidence of best interest meetings and decisions that were in place.

The trust had a dedicated MCA lead that staff could go direct to for advice and guidance. The staff we spoke to knew who this person was and how to contact them.

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

- During the inspection we noted good standards of cleanliness and patients reported the ward was always clean and tidy. In the 2015 patient-led assessment of the caring environment questionnaire Sunflowers court, in which Morris ward sits, scored 100% for cleanliness. This was higher than the national average of 98%.
- The nursing office was large and offered staff a 180 degree viewing window of the ward, looking into the day room, pool room and bedroom corridors. There were internal doors that would restrict staff view of the corridors from the office and risk plans were in place to ensure staff presence and monitoring of all communal areas of the ward.
- Activity rooms were grouped on one corridor on the ward, which was only accessible if accompanied by staff. This included a gymnasium for patients that could also be accessed by other units via a separate entrance to ensure security. We saw evidence that relational security training was updated annually, with monthly reflective practice that incorporated any security issues that had arisen. An assigned security nurse undertook weekly perimeter checks and daily environmental checks of the ward and garden areas.
- The ward conducted annual ligature risk audits and changes were made in conjunction with the health and safety team if a new risk was identified. There was evidence of good ligature risk assessments around the ward, with clear, highlighted mitigating actions where a concern was identified. However, the current ligature risk assessment contained no date for when it was undertaken. This was rectified by the service when we highlighted it to them and they could evidence to us when it was undertaken.
- The clinic room on the ward was well equipped with blood pressure monitoring equipment, blood taking equipment, blood glucose monitoring equipment for diabetic patients and an electro cardiogram machine that all staff were trained to use. The modern matron and physical health lead audited the room with a final sign off from the ward manager monthly.
- All emergency equipment was available and checked daily by a designated member of staff.
- The ward did not have a seclusion room but was in the process of having one constructed during our inspection. Should a patient need to be nursed in seclusion, staff would transfer them to the neighbouring Titian ward, the trust's psychiatric intensive care unit. Medical management of the patient placed there became the responsibility of the staff on Titian ward, until the patient returned to Morris ward.
- The ward was well maintained and clean throughout. Fixtures, furniture and fittings were provided to a good standard and all in working order. The ward had a sluice room with attached toilet facility and locked hatch between them. This allowed for urine samples and drug screening to be processed quickly and efficiently, while also protecting patient's dignity and privacy. The activities of daily living kitchen was well stocked and maintained with a locked sharps drawer, cooker and fridge/freezer. The ward equipment room contained patient lockers and patients had their own keys for secure storage of personal items.
- Infection control audits were conducted annually on the ward to ensure all visitors, staff and patients were at a reduced risk of infection. The current audit demonstrated an improved compliance score from the previous year. The designated security nurse undertook daily environmental checks which also incorporated checks on the ward cleanliness.
- Domestic cleaning staff visited the ward daily, with corridors to patient bedrooms locked for one and a half hours whilst they undertook their duties. Patients did not object to this and it did not appear to disrupt the daily routines on the ward.
- Each member of staff had their own belt which contained attached keys for the ward and a call alarm. Reception held spare belts for non-permanent staff and visitors, and staff were not allowed onto the ward

Are services safe?

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

without having a belt. A key and alarm audit was carried out three times a day where the alarms were tested. Before the issue of a belt, staff were required to read and sign the ward protocol on their use.

Safe staffing

- Establishment levels for the ward were 23 WTE (whole time equivalent) posts. The ward had one FTE (full time equivalent) post for an occupational therapist, which a locum was covering during our inspection. Planned daily establishment levels were five staff in the morning, five in the afternoon and four at night. Turnover rate for the last six months on the ward was 18% and staff commented positively on their stable staff base.
- We saw evidence that staffing levels were increased, dependent upon the acuity of need on the ward, for example with higher levels of observation or to support escorted leave. Additionally, as a result of discussions with the directors by the ward manager and other wards, the trust had recently employed four 'floater' staff that could be called to work on the ward if a shift could not be filled. All staff reported that even in its infancy, this had been a great success and had eased workload pressures.
- When agency and bank staff were used, staff members familiar with the ward were requested to ensure continuity of care for the patients. All agency staff were provided an induction pack to read that contained condensed summaries of important policies for the ward. The permanent staff members on shift would help to orientate agency staff to the ward and brief them on individual patient risks.
- When escorted leave had been cancelled due to staffing shortages, the ward manager attempted to negotiate the leave for either a different part of the day (AM or PM) or move it to another day when staffing would be increased. We were told no leave was completely cancelled and patients agreed that this was fair.
- At the time of the inspection 86% of staff were trained in PMVA (Prevention and Management of Violence and Aggression). The ward had a culture of preventing physical interventions through engagement with patients and staff made it clear that this was their preferred method of managing challenging behaviour. This was aided through the 'mutual help' meetings every morning. This meeting was a safe environment

whereby patients raised any concerns about themselves or the ward environment/culture to the leading member of staff. If patients became upset, they were offered prompt 1:1's with the psychologists, use of the garden(s) and the 'calm down' box which contained a selection of agreed items that patients said would help them to settle.

- There was an on call duty doctor available day and night that was based on site in Sunflowers Court and could be accessed 'within minutes' when required for an emergency. All staff were trained in immediate life support.
- Mandatory training of staff on the ward was all completed by at least 85% of staff members, except for safeguarding adults enhanced (78%) and Mental Capacity Act (75%).

Assessing and managing risk to patients and staff

- We examined six care records of patients from the ward. There were detailed risk assessments for each patient and clear involvement of the patient with their risk assessment. Staff completed a variety of different risk assessments including stalking, sexual and substance misuse. However, one patient had their full unescorted leave rescinded by the Ministry of Justice but staff still allowed unescorted leave to a garden that was away from the ward. The junior doctor on the ward felt the multidisciplinary (MDT) team had appropriately risk assessed the situation, but we had concerns that the patient could vacate the hospital alone.
- There were eleven incidents of restraint over the past six months and two of these involved the use of prone restraint. There had been no episodes of seclusion on the ward for the six months prior to 29 February 2016. However, the ward manager told us of one incident of seclusion since this date which was documented clearly in the patient notes. In this instance, seclusion was used for a short period of time and following review by staff, the patient was transferred back to Morris ward under close observations.
- We saw evidence of good contemporaneous risk assessments of patients completed on admission or within at least 24 hours of admission, which were updated regularly. We saw the use of a validated tool called HCR 20 to help structure decision making on risk of patients on admission.

Are services safe?

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

- Where there were blanket restrictions around the ward such as banned contraband items, these were fully justifiable with clear notices and agreements in place for staff and patients to see. Individual risk assessments ensured other possible blanket restrictions were avoided and ensured the safety on the ward. One example was individual risk assessments for patients to take a razor to their bedroom for shaving.
- The ward had appropriate policies in place to deal with restraint, seclusion and rapid tranquilisation.
- Staff understood the signs to recognise safeguarding issues and could explain the process for raising an alert when needed. The ward had a nominated safeguarding lead that attended trust wide safeguarding meetings and cascaded information and learning to the ward team. There was also a representative from the trust wide safeguarding team who was the first point of contact for safeguarding issues and to discuss further referrals and alerts.

Track record on safety

- There were no serious incidents identified on the ward for the six months prior to 29 February 2016.
- The ward manager alerted us to one serious incident that had occurred since this date, but an incident form

was not completed at the time of the inspection. However, the actions taken by the service ensured the protection of others on the ward and the Ministry of Justice were informed. A serious incident update form had since been completed and lessons were learned from this.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew the procedure on the ward for reporting incidents. A detailed Datix would be logged by staff after any incidents and the ward manager would be alerted. The ward manager considered the incident and discussed with the deputy manager and multi-disciplinary team. Staff were debriefed on the incident and support offered if necessary. The Mental Health Act office was also informed. We saw good documentation in patients care records where incidents had taken place.
- We saw clear evidence of cascading learning from incidents from Morris ward and other wards to staff members. Recently implemented changes included the removal of plastic bags from the ward. Additionally, patients were recently de-briefed and offered support following an incident on the ward.

Are services effective?

Good 

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

- We examined six patients' healthcare records and found that they all contained comprehensive and regularly updated risk assessments, care plans, physical health checks and other information such as leave forms. Care plans were holistic and demonstrated clear evidence of patient involvement. The ward made use of 'My essential inpatient care plan' which included physical and mental health monitoring and 'My personal inpatient care plan' which contained general risk assessments and capacity to consent for treatments.
- We saw evidence of the service encouraging patients to engage with external health services to help with their physical health conditions such as the diabetes service in the nearby King George hospital and attending regular optical and dental check-ups. The ward used a recognised tool called MEWS (Modified early warning score) to help with regular physical health monitoring and responding to any deterioration in a patients' health.
- Care records were very personalised and holistic. We witnessed good discussions at handover which were very person centred and decisions on how the ward were caring and offering support to patients were spoken about, in addition to the input of psychology for emotional support.

Best practice in treatment and care

- The ward pharmacist visited daily and medication charts showed effective medication prescribing and management. Eight patient records were clearly labelled where drug allergies had been identified. Self-administration was closely monitored and assessed regularly. The ward manager and pharmacist undertook missed dose medication audits frequently.
- For new patients, the middle-grade doctor would go through a comprehensive medication review of the last 10 years in order to determine complexity and any treatment resistance.

- All patients had access to psychological therapies and were offered 1:1 or group work with psychologists and psychology assistants. An occupational therapist also worked on the ward and was actively involved in patient treatment.
- HoNOS (Health of the nation outcome scale) was used on the ward as a recognised rating scale to assess and recognise health and social functioning of the patients on the ward and the outcomes of the treatment they were receiving

Skilled staff to deliver care

- The multi-disciplinary team consisted of a variety of mental health professionals including doctors, nurses, psychologists, social worker, occupational therapists and a pharmacist. All staff members we spoke with reported that they felt integrated and utilised within the team.
- All staff we spoke with said they felt they had easy access to specialist training for continued professional development. They all expressed that where this was sought, the ward manager was always supportive of their training needs.
- The ward had set up a monthly teaching programme led by the psychologist who held sessions on the ward for staff covering aspects such as relational security, Mental Health Act basics and various physical health conditions. All staff were alerted by email when refresher training was due and staff reported that the manager was supportive in enabling the completion of training.
- All staff, permanent or temporary, received an induction and orientation to the ward. Mandatory training figures were good and all staff had access to specialist training. The ward ran a monthly teaching programme for staff that was founded by the middle grade doctor on the ward. Monthly reflective practice meetings occurred to discuss any cases or issues that had arisen and helped to ensure a mutual understanding of the patients currently on the ward for all staff members.

Multi-disciplinary and inter-agency team work

- There was close multidisciplinary team working on the ward with all members fully integrated in the team and meetings occurring every week.

Are services effective?

Good 

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.

- We witnessed one handover whilst on the ward which was thorough and detailed for the staff members. They discussed current risk and status of the patients, physical health issues and management of current patient levels of observation. Activities for the day were also discussed which we then saw being negotiated with the patients during their 'mutual help' meeting in the morning.
- Working relationships with local authority services were strengthened by the social worker for the ward, reflected in the zero delayed discharges for the last six months on the ward.

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

- Mental Health Act (MHA) training had only just become a mandatory course for all staff. It was currently offered to all qualified members of staff, with seven members completing it (54%). However, there was no local action plan in place to ensure all clinical staff received this training in a timely fashion.
- Staff had a good understanding of the MHA code of practice and guiding principles. We reviewed the documentation of patients detained under the MHA and found them all to be up to date and in order. Section 17 leave of absence paperwork was all documented, clear and in order with patients unable to take their leave unless they read and signed their section 17 leave form.
- T2 and T3 forms, that demonstrated patients consented to their treatment or had been properly authorised, were present for all patients and attached to their medicine charts where required.
- The patients we spoke with said they were all read and understood their rights on admission and staff would routinely re-read them every four-six months. Each time the patients were re-read their rights, there was clear documentation of this in their patient notes.

- Patients on the ward had access to independent mental health advocates and the services providing these were determined by where the patient resided. There were four requests for advocacy in the last four weeks and patients reported no problems in accessing them. Information on advocacy services was available in the introductory welcome pack from the ward and displayed on the ward notice board. However, the advocacy services did not hold a dedicated, regular drop in clinic for patients.
- However, there was a concern that original Mental Health Act detention papers were archived and only renewal documentation readily available and some staff complained of the slow running electronic note system RiO and the dual use of Windip for certain documentation. This led to confusion in locating certain documents and that staff could not follow the chronology of various documents related to the detention of patients immediately at ward level.

Good practice in applying the Mental Capacity Act

- At the time of the inspection 75% of staff were up to date with their Mental Capacity act (MCA) training and 92.8% for MCA and Deprivation of Liberty Safeguards combined training.
- All patients on the ward were detained under the Mental Health Act and no Deprivation of Liberty Safeguards applications were pending.
- Staff had an understanding of the basic principles of the MCA and there was clear evidence in patient notes that consideration of this had taken place. Where patients lacked capacity to consent, assessments were made on a decision-specific basis and we saw best interest decisions in place. Consent was also sought from patients regarding discussing their treatments and care with family members. Where this was objected to, it was clearly stated in the patient notes.

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 many positive interactions between staff and patients that demonstrated a kind and caring atmosphere on the ward. All staff spoke respectfully about patients and demonstrated they clearly understood the needs of all individuals on the ward. Staff would always knock on bedroom doors before entering. There was evidence that patient's emotional needs were considered in decisions regarding their care.
- All patients we spoke with were complimentary about staff attitudes towards them. Patients reported that all staff were polite to them and there was a mutual respect amongst staff and patients. All patients felt involved in their care and supported in their recovery. Patients were afforded opportunities to 'have their say' through chairing community meetings and felt confident on how to make a complaint. The ward had a very calm, friendly and relaxed atmosphere.

The involvement of people in the care that they receive

- Sunflowers Court scored above both the trust's overall score (86%) and the national average for England (86%) for 'privacy, dignity and wellbeing' with a score of 88%. Patients we spoke with explained that they had a day on the ward before admission to ease their anxieties. All new admissions received an introductory 'welcome pack' for the ward that contained information on the multidisciplinary staff team, prohibited items, individual rights and routines. An introductory pack was also offered to family members detailing important information on visiting hours, support, interpreters and advocacy. All patients were orientated to the ward by a member of staff who gave them a tour and explained the procedures of the ward. All patients were assigned a named nurse and patients expressed they were comfortable to approach them for any information.
- All patients were invited to attend any reviews of their care and treatment involving the multi-disciplinary team and were provided with advocacy services to

assist them with this. We saw evidence in the care records that patients were actively involved in devising their care plan and had adequate opportunity to comment on them and have their views detailed. All patients signed and were offered a copy of their care plan. Where patients had refused a copy of their care plan, this was well documented. The patients we spoke with all received copies of their care plan and were given enough information regarding their treatment. A member of the nursing team would review and agree care plans with the patients every week.

- Patients on the ward had access to one of three advocacy services depending upon the borough in which the patients resided. Patients had to request these services or be referred by a member of staff and the advocate would also be invited to ward rounds to discuss the individual's treatment. Information on the advocate services was available to view on the notice board on the ward. However, the advocacy services did not hold a dedicated, regular drop in clinic for patients.
- Family members and carers were actively encouraged and supported to be involved in the patients care. The psychologist on the ward held family and carer's intervention groups monthly and offered 1:1 sessions with family members. Family members were offered carers assessments on the ward by a social worker.
- Community meetings were held weekly and chaired by patients. The patients told us they were confident in raising issues and concerns at these meetings and felt they were heard. These meetings incorporated a 'you said, we did' section from the staff members to highlight the work done following patient comments. Additionally, every morning the ward held a 'mutual help' meeting that discussed the activities and routines for the day. This time allowed issues to be raised and we saw one such example regarding cold showers being followed up by staff members. The trust encouraged patients to complete a questionnaire on their stay in the service following discharge and the ward manager had devised their own similar survey to reflect the longer staying nature of the patients on the ward.

Are services responsive to people's needs?

Outstanding



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

Our findings

Access and discharge

- Average bed occupancy for the last six months was 94%. When we visited the ward, all beds were occupied. Average length of stay of patients as of December 2015 was 73 days. The average length of stay of patients who had been discharged in the last 12 months was 1009 days (3 years). The trust informed us the service had no patients from out of the area admitted to Morris ward and no patients were placed out of area.
 - The social worker on the ward had recently implemented a discharge support group for patients due for discharge because patient's expressed their anxiety towards being discharged. The ward offered a three month follow up with the psychologist after discharge to prevent readmissions to the service. This work was not funded or commissioned, but the team felt it was a very important service to offer for patients. The social worker had set up a community links group to further ease the transition once out of hospital. This group occurred out of normal working hours and invited major stakeholders in patient care (vocation/education providers/accommodation providers/voluntary groups) from the community to speak with patients about services that could assist them in recovery on the ward and in the community.
 - The ward had good links with the local college and some patients were learning trades and gaining formal qualifications to help with recovery and better prepare patients for when they left the hospital. The college was also invited to the ward to talk to patients about the benefits of attending the college and promote the courses on offer.
- visit a local farm centre. This organisation aimed to promote mental and physical health, social inclusion, intercultural awareness, and environmental sustainability through organic food harvesting.
 - The service had a private family room off the reception area and away from the ward where patients could meet with their family and carers in private. This room was additionally used for patient searches on return to the ward. Family members and friends were first assessed by a social worker before contact could be made with the patients. The ward contained a 'quiet' room that could be accessed by patients which contained a selection of reading books.
 - There was a multi faith room that contained a prayer mat and patients could request various religious texts that were kept in the staff room. The ward had clear, dedicated times for patients to make a phone call that were advertised in the introductory welcome pack and on posters around the ward. The interview room contained a telephone that patients could make a call from, with incoming calls being transferred to this room for privacy, once the caller had been identified in the staff nursing room. There was also a TV in a locked cabinet in the lounge and pool table available for use in the games room.
 - Patients told us that there was a good choice of food and we saw that food choices and requirements were always respected and met. However, some patients did explain that the quality of food was not good.
 - The kitchen contained tea, coffee and juice making facilities that were available 24/7. The ward had a policy that hot water should be below 60 degrees Celsius and therefore could not meet this with the installation of a hot water dispenser. As a result, the ward offered hot water under this threshold in large flasks that patients could access.
 - Patients were allowed to personalise their bedrooms, but we saw little evidence of this in practice. There was clear evidence of artwork created by the patients being used to decorate the reception area and the activity rooms.
 - All patients had their own keys for their bedrooms and could access them at all times, except during routine

The facilities promote recovery, comfort, dignity and confidentiality

- The ward was very well equipped with a range of rooms dedicated to clinical needs, therapeutic interventions and activity rooms. Patients had access to two different secure gardens attached to the ward. One was a regular open space garden with football goals, netball hoops, table tennis facilities and a BBQ and seating area. The second garden was dedicated for use by some patients with the occupational therapist as an allotment to grow their own vegetables. This horticultural club would also

Are services responsive to people's needs?

Outstanding



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

cleaning. All patients had their own secure locker where they could store personal possessions. All the patients we spoke to said that they felt their possessions were safe and secure at all times.

- Activities were provided for patients seven days a week. They were provided by an occupational therapist and an occupational therapy assistant. The service offered a range of activities both on the ward and in the community that was varied and recovery orientated. Activities included table top games, arts and crafts, gymnasium, swimming, football, the allotment and cinema. The ward had a very good relationship with a local professional football club and developed a programme called 'coping through football'. This programme offered six patients the opportunity to train with the professionals twice a week and additionally received free tickets to home matches at the weekend. The ward manager was very open to requests from patients regarding activities and had recently arranged for the provision of karaoke due to a request.

Meeting the needs of all people who use the service

- The ward had good disabled access throughout, with wide doors, corridors and disabled toilets.
- Full-time carer support was offered to patients whose needs required this.
- The introductory ward 'welcome pack' contained information regarding local services, patient rights and the complaints procedure. Additional information was posted on the ward notice board including which members of staff were on duty that day. All patients felt they were given sufficient advice, information and choice on their treatments and care.

- Interpreters were offered and used by family members of patients to encourage their involvement and overcome any language barriers. We were told that 'Skype' technology was also used by the ward to involve family members and carers who could not attend ward rounds, Care Programme Approach (CPA) or multidisciplinary (MDT) meetings to allow them to still be involved in the patients care.
- Local faith representatives could be contacted and requested by patients and a chaplaincy service attended the ward regularly.

Listening to and learning from concerns and complaints

- The service had received no complaints for the previous 24 months.
- Patients expressed that they knew how to make a complaint regarding the service and felt confident in doing so. Most patients said they would make use of the complaints letter available on the notice board, with one patient saying they would also be happy to tell a member of staff informally. One patient who had previously made a complaint said they received a letter explaining the trusts response and was very satisfied with it.
- The staff we spoke with knew the procedure for logging complaints and explained they would be happy to help patients do this both formally and informally. We were told 'smaller' complaints would be dealt with unofficially at a ward level but anything more would be done formally. Community meetings were used for patients to raise any issues with the service and a complaints box was available on the ward. After resolution of complaints, information was cascaded at handovers and staff meetings.

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

- The trust's vision and values were on display in the ward and staff said they agreed with and understood them. The values were well implemented into the local objectives for the team.
- The ward manager had regular contact with the matron and senior management. Other staff members on the ward said they were aware of who the senior management were. We were told that the senior team visited the ward regularly.

Good governance

- Most of the staff were up to date with mandatory training and staff received automated emails for refresher training. The ward manager was reported as being supportive of staff training. However, there was no local action plan in place to ensure all clinical staff received their training in a timely way. As a result, the ward manager could not immediately book staff onto courses when asked at the time of our inspection, as there were no more available spaces in the future.
- All staff on the ward had received their annual appraisals, except for the ward manager as the matron of the ward was new in post. Staff received monthly supervision and a newly qualified member of staff received supervision every fortnight.
- The ward had a minimum of five staff on duty and at least two qualified nurses at all times. We were told that should staffing levels not be fulfilled, this would be reported as an incident and the ward would be unable to respond to psychiatric emergency team calls. However, we were informed and saw evidence that staffing levels below the minimum were very rare. Additionally, the ward had one band six nurse as supernumery who was the bleep holder/nursing officer and would respond to calls from the section 136 suite.
- Many clinical audits were undertaken on the ward including Section 17 leave audit, seclusion audit, care plan audit and Section 132 audits.

- We saw good evidence that safeguarding, Mental Health Act and Mental Capacity Act procedures were followed. There was good evidence in the notes surrounding mental capacity assessment for treatments and we saw best interest meetings and decisions in place.

Leadership, morale and staff engagement

- Morale on the ward was excellent. All staff spoke highly of the team dynamics and felt the leadership was strong. One staff described it as a 'great honour' to be working as part of the forensic team and this was reflected in all interactions we witnessed between staff. The ward manager was visible and accessible to staff on the ward at all times.
- The ward had a sickness and absence rate of 4% for the six months prior to 29 February 2016.
- The ward team had a friendly, relaxed and professional feel to it and there were no instances of bullying or harassment previously or expressed by the staff we spoke to. Staff were aware of the whistleblowing process if they needed it.
- All staff we spoke to felt happy and comfortable in raising issues or concerns regarding their experiences on the ward and would not be afraid to take issues to a more senior member if required.
- Staff felt supported by all members of the team and were very happy with the dynamics on the ward. Staff felt that the workload was manageable.

Commitment to quality improvement and innovation

- The ward participated in 'Safe wards'. Safe wards is a programme developed to engage patients in their care, rather than to simply 'contain' them.
- The ward held membership with the Quality Network for Forensic mental Health Services. This group reviews forensic services throughout England and staff from the ward participated in review teams to help share expertise and knowledge as well as highlighting areas of improvement and good practice.

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.

This section is primarily information for the provider

Enforcement actions

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.