West London NHS Trust

Forensic inpatient or secure wards

Inspection report

Trust Headquarters
1 Armstrong Way
Southall
UB2 4SA
Tel: 02083548354
www.westlondon.nhs.uk

Date of inspection visit: 14,15 and 16 February 2023
Date of publication: 19/05/2023

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Requires Improvement**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Forensic inpatient or secure wards

Inspected but not rated

We carried out this announced focused inspection to check on the safety and quality of the service at the women's forensic service at The Orchard Unit. We looked at specific aspects of safe, effective, caring, responsive and well-led.

During this inspection, we looked at The Orchard Unit only. The Orchard Unit is a women's service and provides low secure, medium secure and enhanced medium secure (known as WEMSS – women's enhanced medium secure services) wards. There are a total of six wards. We did not inspect the thirteen male secure wards provided by the trust. The data we reviewed applied only to The Orchard Unit.

We did not re-rate the overall service following this inspection and it remained outstanding overall which was the rating at the last comprehensive inspection in December 2018.

We limited the rating for safe at this inspection to Requires Improvement as we found a breach of regulation. The effective, caring, responsive and well led domains were not rated at this inspection as we were not inspecting the whole forensic service and there was no breach of regulation.

We carried out this inspection because of information of concern shared with us through our national customer service centre.

As part of our inspection we visited:

Aurora ward – 10 bedded women's medium secure admission ward

Garnet ward – 10 bed women's medium secure rehabilitation ward

Pearl ward – 15 bed women's low secure ward

Melrose ward – 10 bed women's enhanced medium secure admission ward

Parkland ward - 10 bed women's enhanced medium secure admission ward

The West London Forensic service covers eight boroughs in North West London – Ealing, Hammersmith and Fulham, Kensington and Chelsea, Harrow, Hillingdon, Westminster, Brent and Hounslow. It is part of the North London provider collaborative.

The previous comprehensive inspection of this core service was in September 2018.

At that inspection, we rated the service as outstanding. We rated the service as good for the domains of safe, effective and responsive. We rated caring and well-led as outstanding.

West London NHS Trust is registered to provide the following regulated activities:

Our findings

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

Our findings from this inspection were as follows:

- The ward environments were safe and clean. Patients told us that they were safe. Carers confirmed that their family members were looked after safely. All staff spoke about safety being a priority. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Staff from different disciplines worked together to make sure clients had no gaps in their care. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and valued them as partners in their recovery. Staff actively involved patients and families and carers in care decisions. There was a strong person-centred culture which met patients' unique needs and was embedded throughout the service. Staff helped patients with communication, advocacy, cultural and spiritual support.
- Co-production and person-centred care were at the heart of the service. We saw numerous examples of patients being involved in changes and development of the service, including reducing restrictive practices, focus groups on restraint and the co-production of a patient leaflet on racism and its effects on patients and staff.
- Staff planned and managed discharge well and liaised with services that would provide aftercare.
- The service was well-led and the governance processes ensured that ward procedures ran smoothly.

However:

- Whilst the service had a robust improvement plan for the recruitment, retention and development of qualified and non-qualified nursing staff, vacancy rates remained high.
- Intermittent observations were recorded at regular and predictable intervals. There was a risk that the patients would know when observations would take place and they could plan any actions around this.
- On Garnet ward, the connecting bathroom door in the seclusion suite was kept locked. There was a potential risk of injury to staff and the patient in seclusion whilst the bathroom door was being opened.
- Long-term segregation (LTS) care plans did not contain sufficient detail about how LTS was to be brought to an end, did not reflect the patient voice and did not reflect the recommendations from external reviews.
- On Parkland ward one medicine incident had not been reported in line with the trust policy.

Our findings

- Team meeting minutes varied in the quality of information recorded. Learning from incidents was not a regular agenda item.
- Eight carers we spoke with did not have awareness of the carers forum. Minutes of the main carers meeting were not kept, which meant that there was no audit trail on any actions that required follow up.

The team that inspected the hospital comprised a CQC lead inspector, one inspector, one pharmacist inspector, two inspection managers, one Mental Health Act reviewer, one expert by experience and one specialist professional advisor who had experience of working in forensic services.

Before the inspection visit, we reviewed information that we held about the service. This was an inspection of this service.

During the inspection we asked the following questions:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive?

• Is it well-led?

During the inspection visit, the inspection team:

- visited five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- carried out a Mental Health Act review visit on Garnet ward
- observed and attended three clinical team meetings, one handover meeting, one reducing restrictive practice focus group, one blanket restrictive practices women's steering group, one community meeting, patient focus group and two long term segregation reviews
- spoke with 16 patients who were using the service and nine carers or family members of patients who were using the service. Interviews with carers were completed by telephone. Our final carer interview was on 15 March 2023
- spoke with the chief operating officer for forensic services, service director, clinical lead, head of social work and clinical director
- spoke with 21 other staff members: including consultant psychiatrists, ward doctors, nurses, healthcare assistants, clinical psychologist, practice development nurses and the physical health lead
- looked at eight care and treatment records of patients
- reviewed medicine management on Parkland and Melrose wards
- looked at a range of policies, procedures and other documents relating to the running of the service
- carried out observation exercises on Aurora and Parkland wards

Our findings

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

What people who use the service say

Feedback from patients was very positive about the care and treatment they received from staff. Patients told us they felt safe, valued and respected. They told us that staff treated them with compassion, kindness, dignity and were non-judgemental. Patients said staff listened to how they were feeling and supported them to understand their care. Patients told us that they were aware of their care plans and were actively involved in their development and review so that they had the support they needed in the way they wanted. Patients told us they had numerous opportunities to attend vocational courses, education and paid employment. Some of the comments we received included 'I have made huge progress', 'here we are listened to, we have a voice, we are not judged, 'they have helped me build my confidence and 'I have developed new skills'.

We spoke with nine carers. Overall feedback from carers was positive about the care and treatment their family members received. They told us that their family members were safe and well looked after. Carers told us that they were involved as much as their family member wanted them to be. Comments we received included 'my relative is in safe hands', 'staff are respectful and listen well' and 'I am really happy with the care'. Eight of the carers we spoke with did not have awareness of the carers' forum.

Two carers told us that there was a lack of communication from the ward staff. One carer reported that they did not know when carer meetings were held and being invited to care programme approach (CPA) meetings at short notice. One carer told us that the lack of social worker on the ward made care coordination difficult but was aware that recruitment was taking place. Other carers told us they had regular contact with their social workers and were kept updated about Care Programme Approach (CPA) meetings and Mental Health Act tribunals.

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We did not inspect the whole of the key question during this inspection but as we found breaches of a regulation this limited the rating to requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. However, on Garnet ward the connecting door to the bathroom in the seclusion suite was kept locked preventing the bathroom from being routinely accessible.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff carried out a health and safety check of the ward environments each hour on each shift.

The layout of the wards did not allow for clear lines of sight in every area. Where there were blind spots these were mitigated by convex mirrors to improve visibility, staff observations, engagement with patients and understanding of relational security through knowledge of individual patients. Nursing staff were able to observe patients in the communal areas of the wards at all times.

Our findings

Closed circuit television (CCTV) was in place in the corridors and communal areas and recorded any activity taking place.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe, for example, by using observation, provision of protective clothing and blankets, engagement and individual risk management plans for each patient.

Ligature audits had been carried out in February 2023. Ward managers were working with the health and safety team to review the audits in line with the trust ligature audit policy. Ligature audits included a ligature heat map and blind spot audits.

Ligature cutters were available on each ward and staff knew where to locate them in the event of an emergency.

Staff practised what to do in an emergency situation during scenario training on the wards. The physical health lead carried out unannounced emergency simulation training. A simulation exercise was carried out in October 2022, records showed learning actions following the exercise. However, staff on Aurora ward told us that they had not been involved in any simulation exercises.

A fire risk assessment had been carried out for The Orchard Unit in May 2022. Where required, staff completed personal emergency evacuation plan (PEEP) for patients who had mobility difficulties.

Fire drills had been paused during the COVID-19 pandemic. We saw a schedule where these were due to recommence. All staff had undertaken fire safety training as part of their mandatory training.

Staff had easy access to personal alarms and patients had easy access to nurse call systems. Staff alarms and radios were checked daily by the security team before the start of each shift. During our inspection we observed staff reacting swiftly when alarms were activated.

Maintenance, cleanliness and infection control

Ward areas were visibly clean, well maintained, well-furnished and fit for purpose. There was an ongoing programme of redecoration and refurbishment. Work was taking place to build sensory rooms throughout The Orchard Unit.

Staff reported that the maintenance team responded promptly to any maintenance issues.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were seen cleaning high touch areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment (PPE) including aprons, masks, gloves, and hand sanitiser was readily available. Infection control audits were undertaken on each ward including regular hand washing audits. Audit findings and actions were discussed in handover and staff meetings if any issues were identified.

Staff accessed infection control training. All wards had training compliance of 85% and above.

Staff could seek support from the infection prevention control lead within the service.

Our findings

Seclusion room

The seclusion rooms were clean, well-maintained and compliant with guidance in the Mental Health Act Code of Practice. Seclusion rooms allowed clear observation and two-way communication and had toilet facilities and a clock visible to patients. However, on Garnet ward we found that the clock kept flashing and required a new battery. We also found that the connecting door to the bathroom was kept locked preventing the bathroom from being routinely accessible. When a patient wanted to use the bathroom, staff were required to enter the bathroom and open the connecting door to allow the patient access. This meant that there was a potential risk of injury to both staff and the patient in seclusion whilst the bathroom door was being opened.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinical rooms were clean, spacious and equipped with handwashing facilities.

Staff had access to equipment for use in medical emergencies and this equipment was checked daily. Oxygen cylinders were stored securely. Blood glucose testing kits were being calibrated appropriately. We saw records to confirm that medical equipment was portable appliance PAT tested to ensure suitability for use. Staff attached stickers to equipment showing the date that the item was last cleaned, these stickers were visible and in date.

Staff were monitoring the temperatures of medicines storage areas daily. Staff knew how to escalate any out-of-range temperatures. There was an issue with the fridge on Melrose ward and staff had taken appropriate action to safeguard medicines supplies.

Safe staffing

The service did not have enough substantive nursing staff and had to use bank and agency staff to provide safe staffing levels to patients.

Nursing staff

With the use of bank and agency staff the service had enough nursing and support staff to keep patients safe and to provide the right care and treatment. Staffing levels across each ward were reviewed daily within the service. Staffing numbers were displayed on each ward in the communal areas so patients and visitors could see them.

Vacancy rates for registered nurses and healthcare support staff were high due to national shortages of nursing staff. Vacancy rates were high for all band 5 registered nursing posts with Melrose ward having the highest at 52%, followed by Parkland ward at 40%. Aurora and Melrose wards had the highest vacancies for band 3 support workers at 32%. To manage the risk the service had paused new admissions following discussion with the commissioners to Parkland and Melrose wards.

The service was finding it challenging to recruit registered nurses despite using both tried and tested and creative recruitment methods. There were continuous advertisements for nursing staff vacancies. Recruitment events with universities were taking place at universities and at the service. To attract staff the service was looking to pay a retention and recruitment premium and offer flexible working. The service had recently employed a dedicated recruitment manager.

The service had high rates of bank and agency nurses and health care support workers. A total of 15715 shifts were filled by bank and agency staff from 1st February 2022 to 1st January 2023. A total of 819 shifts had not been filled in the same period. 116 health care support worker bank shifts had not been filled on Melrose and 74 shifts on Parkland. Garnet ward

Our findings

had the highest number of registered nurse bank shifts at 58 and 39 on Parkland ward. Where possible additional health care support staff were on duty when registered nurse cover could not be found. The service was aware that there was a risk that relational security could break down with the increase number in temporary staff. Staffing, recruitment and retention was the top risk on the service risk register.

Where possible managers limited their use of bank and agency staff and requested staff familiar with the service. Agency staff where possible were offered block contracts.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. All bank and agency staff we spoke with confirmed they had undertaken an induction. Bank staff received the same access to supervision and training as permanent staff.

The sickness rate for the 12 months to January 2023 service was 7%.

The turnover rate for the 6 months to February 2023 was 8%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Any concerns were escalated to the unit coordinator for the service. The unit coordinator could adjust staffing levels across the wards according to the acuity of patient needs and patient risk.

Managers supported staff who needed time off for ill health. Staff confirmed their managers were understanding and supportive when this happened.

Patients had regular one to one sessions with their named nurse. These sessions were clearly recorded.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. All leave cancellations were monitored at the ward clinical improvement group (CIG).

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Staff held handovers at the beginning of each shift. Staff also completed a handover book with key information relating to the core care needs of each patient. On the WEMMS wards the service had introduced a multi-disciplinary team handover on a Monday, Wednesday and Friday to ensure essential information was handed over to the team on one occasion.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Vacancy rates for consultant psychiatrists were at 15%. The 0.5 WTE vacancy was covered by a locum with many years' experience of working in The Orchard Unit.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

Our findings

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with said they felt confident carrying out their role and applied training to their practice. They were fully supported to carry out any additional required training, for example some staff had carried out training on British Sign Language, positive behavioural support and diabetes care.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training sessions were provided either in person or virtually.

Staff had received and were mostly up-to-date with appropriate mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. However, on Garnet ward clinical risk training was at 73%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, intermittent therapeutic engagement and supportive observations were being carried out at predictable times.

Assessment of patient risk

Staff completed comprehensive risk assessments of every patient on admission. Risk assessments were reviewed and updated regularly, including after any incident. Care records viewed had up-to-date risk assessments.

Staff used a recognised risk assessment tool. The hospital used the HCR-20 (Historical Clinical Risk Management) risk assessment tool to ensure that all aspects of patient risk were covered. We observed a multi-disciplinary clinical team meeting on Melrose ward at which staff reviewed individual risk and management plans. For example, the team took time to discuss a patient's request for specific items. We saw that the multi-disciplinary team balanced the needs and preferences of the patient with their level of risk before deciding whether the patient could have the items.

Management of patient risk

Person-centred risk management processes were in place to anticipate, manage and reduce the risks of patients experiencing harm. Staff had open conversations with patients concerning their risks and produced a safety plan in collaboration with them.

Staff knew about any risks to or from each patient and acted to prevent or reduce risks. Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and multi-disciplinary meetings included all the necessary key information to keep patients safe.

Staff in multi-disciplinary team meetings comprehensively discussed individual patient's needs and demonstrated an in-depth understanding of each patient. Staff regularly discussed patient dynamics within the teams and across the wards to ensure patients were kept safe. Staff were fully aware of risks to patients, themselves or to others. For example, we saw that protective/tear-proof clothing and towels were in place for some patients who were at high risk of ligature incidents.

All patient leave was risk assessed. Staff completed pre and post leave risk assessments for each patient.

Our findings

Staff identified and responded to any changes in risks to, or posed by, patients. The multi-disciplinary team on each ward attended daily safety huddles. However, staff on Aurora ward reported that members of the multi-disciplinary team were not always able to attend. Safety huddles focused on sharing information, assessing and reviewing patient safety, identifying other safety concerns and effectively communicating any changes in how individual risks were being managed.

Ward staff could call on extra support from the other wards in an emergency. Each ward had a designated staff member on each shift that was part of the emergency response team. This team responded to incidents of violence and aggression and any physical health emergencies. We observed the team respond to an incident on Aurora ward. Staff were observed to be professional and dealt with the situation skillfully, providing support to the patient and staff involved.

Staff could observe patients in all areas and observed patients in line with the trusts policies and procedures. Staff checked all patients at least once during every hour. These are called general observations. When patients presented a heightened level of risk, this was increased to four times within one hour or every 30 minutes. All levels of observations were agreed and reviewed by the multi-disciplinary team.

Staff reported that they had undertaken training in therapeutic engagement and supportive observations (TESO). Bank and agency staff completed a TESO checklist to ensure they understood what was required when a patient required TESO observations. We reviewed intermittent observation records for four patients. All four records showed that intermittent observations were being carried out exactly to the 15 minutes. By conducting observations at exactly the same time within a specific time period there was a risk that patients could predict what time staff would be observing them and plan to harm themselves in between times.

When we asked staff about intermittent observations, some staff were aware of the risk associated with regular, and therefore predictable, intermittent observations and some staff were not. The TESO policy stated that 'clinical evidence suggests that within the agreed time frequency staff should stagger the timing of therapeutic engagement and supportive observation.' The policy was due for review by the deputy director of nursing.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. All patients were searched when returning from leave off the ward or if there were any individual safety concerns. Patients were also subject to random breathalyser and drug screening.

Use of restrictive interventions

Levels of restrictive interventions were low. Between 1 August 2022 and 31 January 2023 there were a total of 25 restraint incidents across the six wards involving 20 patients. Eight of these were prone restraints. Each episode of restraint was discussed, reviewed and analysed within the multi-disciplinary team. The team also discussed whether the restraint could have been avoided.

Reducing restrictive practices were discussed at the monthly ward and directorate clinical improvement group meetings. Minutes from these meetings showed that restrictive interventions such as blanket restrictions were discussed and patient feedback sought, for example patients on Pearl ward were requesting to trial smart phones on the ward.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff were trained in the prevention and management of violence and aggression (PMVA). PMVA training in the service was co-delivered with one or more patients.

Our findings

The service worked collaboratively with patients and staff in understanding restraint and how people's experiences could inform the training provided by running a series of focus groups.

The service used initiatives based on the 'Safewards' model. This included increasing safety, reducing conflict, calmer environments and de-escalation and alternatives to restrictive interventions.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Minimisation of the use of restrictive interventions was embedded within the service as business as usual. Staff were aware of the potential triggers for each patient as well as the dynamics between patients on the wards. Staff we spoke with confirmed that restraint was used as a last resort. Staff were trained in managing actual or potential aggression. This training provided staff with skills on how to de-escalate situation, such as listening to patients who were becoming agitated, responding to their concerns and distracting patients from things that were causing distress.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff were aware of National Institute for Health and Care Excellence (NICE) guidance on the use of rapid tranquilisation and staff were aware of how to carry this out safely and conduct physical observations after its use. We saw minimal use of rapid tranquilisation medicines. Between 1 August 2022 to 31 January 2023 rapid tranquilisation had been used once. The trust policy supported staff to use the least restrictive practice.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Nursing observations and medical reviews were taking place for those patients in seclusion. Between 1 November 2022 to 31 January 2023 there were 20 episodes of short-term seclusion across the six wards.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation (LTS). Between 1 January 2022 and 31 January 2023 there were 56 episodes of LTS. The service tracked all episodes and duration of LTS.

At the time of our inspection there were two patients in LTS. We reviewed records for both patients.

There was evidence of nursing observation and medical reviews taking place regularly as required by the Mental Health Act Code of Practice. Nursing and medical reviews were clearly documented. Records demonstrated the rationale and continuing need for LTS. Both patients had a detailed seclusion care plan and seclusion exit care plans. However, we found that these care plans did not include sufficient detail about how LTS was to be brought to an end. We observed the multi-disciplinary teams review of both patients in LTS and obtained their feedback, there was very little evidence of the patient voice/involvement in the LTS care plans in the documentation made available for us to review.

For patients that have been in LTS for 3 months or more, external reviews are undertaken by an external hospital. For both patients we saw that there were no references within the LTS care plan on the recommendations made at the last external review.

There were robust governance arrangements in place to ensure that there was good oversight of the use of restrictive interventions in the service. Monthly restrictive intervention reduction, monitoring and review meetings were held, minutes showed that all restrictive interventions across the forensic service were reviewed. This included use of restraint, blanket restrictions, leave, use of rapid tranquilisation and service user feedback.

Our findings

The service engaged with the Independent Care (Education) and Treatment Review (ICETR) programme to ensure that patients who were cared for in long term segregation had an independent review of their care.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had clearly defined and embedded systems, processes and policies to keep people safe and safeguarded from abuse. Staff received regular safeguarding training and took a proactive approach to safeguarding patients. Safeguarding concerns were regularly discussed in multi-disciplinary team meetings, handover meetings and referrals were discussed in clinical governance meetings, for example on Garnet ward following safeguarding concerns staff now wore body worn cameras when carrying out observations on a patient.

All safeguarding referrals were tracked by the head of social work within the service. The service had a good working relationship with the local safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had immediate concerns. Each ward had an allocated social worker who led on safeguarding referrals, they were able to provide support and advice to ward teams. Staff on Parkland ward were able to describe how they had used mediation to support two patients who were in conflict. Mediation had improved the relationship between the two patients.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, for example, where patients identified as transgender staff used their preferred pronouns.

Staff followed clear procedures to keep children visiting the service safe. All visits were risk assessed as being in the child's best interests. There were dedicated visitor's rooms, off the wards which were used for family visits and were age appropriate.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff including bank and agency could access them easily.

When patients transferred to a new ward, there were no delays in staff accessing their records, as the electronic records could be accessed by anyone working within the hospital.

Records were stored securely. Staff needed to enter a personal identification, a password and use an identity card to access the electronic patient record.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

Our findings

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines at the weekly multi-disciplinary team meeting. We observed patients discussing their medicines with the multi-disciplinary team at all three ward rounds we attended.

On Pearl ward there were systems in place to facilitate some patients to take responsibility for administering their own medicines, following a comprehensive risk assessment, and appropriate staff support.

Staff conducted weekly physical health checks for each patient. Staff could access a physical health team of registered general nurses within the service who supported them in this area. Staff facilitated patients and carers to speak to a pharmacist about their medicines if they wished to do so.

Staff stored and managed all medicines and prescribing documents safely. All records included details of assessments of the patient's capacity to consent to the medicines that were prescribed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. We saw evidence that staff completed medicines reconciliation when patients were admitted or moved between services.

Staff learned from safety alerts and incidents to improve practice. The trust had a system of ensuring that staff were informed of patient safety alerts which was outlined in the medicines policy. Staff had an electronic system for reporting and investigating medicines incidents. Records were kept of actions taken. However, on Parkland ward we saw that hydrocortisone cream had not been signed for 13 days. This meant it was not clear whether the patient had been administered the cream as prescribed. We could not see an incident report for this in line with the requirements of the trust medicines policy.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the use of rapid tranquilisation at each multi-disciplinary meeting and at the reducing restrictive practices group. Staff also sought patient feedback to hear their views on restrictive practices.

The ward pharmacist attended the multi-disciplinary team meeting. There was good clinical input by the pharmacy team in optimising patients' medicines and providing support to both medical and nursing staff, as well as advising patients, and making clinical interventions with medicines to improve safety.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff ensured each persons' physical health was monitored regularly. They made use of the National Early Warning Scores (NEWS) to improve detection of and response to clinical deterioration. Patients had regular blood tests and electrocardiogram (ECG) readings taken.

Track record on safety

The service had a good track record on safety.

There had been eight serious incidents in the service in the 12 months before the inspection. Incidents related to self-harm behaviour, one patient death, patients assault on staff and medicine concerns.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Our findings

The service managed patient safety incidents well. All staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff told us that they would report any incident of harm, potential harm and/or risks to safety. Managers had oversight of incidents and these were reviewed in the monthly ward clinical improvement and directorate clinical improvement group meetings. The service ran a weekly serious incident clinic which key members of the senior management team attended. This ensured that serious incidents are identified correctly, investigated and learned from to prevent similar incidents reoccurring.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Managers debriefed and supported staff after any serious incident. All staff confirmed they had high levels of support from the staff team and senior managers when incidents had occurred. Reflective sessions took place weekly on all wards except Damson where they were held fortnightly. These were facilitated by a psychologist, nurse or arts therapist, all linked to the forensic psychotherapy department for supervision of this work. Patients were offered a debrief after each incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff reported serious incidents clearly and in line with trust policy. Staff completed a report on the circumstances of the incident within 48 hours. All serious incidents had a comprehensive investigation and action plan for any shortfalls identified.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff said they were well informed about incidents and met to discuss the feedback and look at improvements to patient care and safety at handovers, intranet, emails, staff forums, multi-disciplinary team meetings, CIG and clinical governance meetings. We saw that apart from Garnet ward, learning from incidents was not a standing agenda item at ward staff meetings.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, following recommendations from a serious incident investigation all staff at the service now had details of the address of the unit to give to emergency services. This was now attached to staff lanyards. This learning was shared across all wards within the service.

Is the service effective?

Inspected but not rated

We did not inspect the whole of the key question during this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Our findings

There was a holistic approach to assessing, planning and delivering care and treatment to patients. There was a strong focus on recovery.

Staff completed a comprehensive mental health assessment of each patient on admission. This included a mental state examination and an assessment of any risk the patient presented. Where required, clinical psychologists completed a functional behaviour assessment for patients with a learning disability.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Staff reported that physical health information from previous placements such as prisons and hospitals were obtained to gain a full picture of the patient. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiograms.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Where required, patients had a detailed positive behaviour support plan and staff were required to use a positive behaviour approach when supporting them.

Care plans reflected the patient's voice, views and involvement about their care and treatment. Staff worked with patients to regularly review and update care plans when patients' needs changed. The multi-disciplinary team reviewed every patient each week and updated each patient's care plan with the patient's involvement actively encouraged and supported.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE). Staff teams provided a range of individual and group interventions which included medicines, psychological therapy, education, anger management, understanding trauma, sexual safety, cyber safety, art, yoga and complementary therapies and positive behaviour support.

Patients had access to a wide range of evidence based psychological therapies as recommended by NICE, including group and individual support. This incorporated dialectical behavioural therapy, cognitive behavioural therapy, Schema therapy, psychodynamic psychotherapy and family therapy. All therapy was tailored to meet patient's individual needs.

Staff identified patients' physical health needs and recorded them in their care plans in a simple format that helped to understand and share information. Staff made sure patients had access to physical health care, including specialists as required. For example, a patient had been taken to hospital following several seizures.

Patients could access a physical health centre in the service. Wards were supported by specialist physical health leads, registered general nurses (RGNs), locum GP, dentist, dietician and physiotherapist. The team were in the process of recruiting a physical health care pharmacist part to look at medicines and possible metabolic syndromes that affected patients. The service had access a diabetic nurse specialist across the North London forensic collaborative and a

diabetic consultant held a 3 monthly virtual clinic. The team were monitoring the number of women with diabetes, pre-diabetes and patients with a body mass index (BMI) over 30. The specialist physical health nurse reviewed all diabetic patients except those on insulin who are seen by the specialist diabetic nurse. The specialist diabetic nurse held a 6-weekly clinic. We saw that the service had a dedicated drugs and alcohol team to support patients with substance misuse. Care plans recorded the support the team offered to meet patients individual care and treatment needs.

The senior physical health lead nurse supported staff to improve their skills and knowledge of all the conditions experienced by patients on the wards. The senior nurse provided training for staff on topics such as wound care, diabetes, NEWS2, and any aspect of physical health care they needed to learn more about. This helped staff to upskill their knowledge and support for patients on the wards. They also provided skills training in ECGs and phlebotomy.

Training information showed that all staff had been trained in NEWS2.

The clinical team were working on developing an autism strategy for the service. Some of the work that had taken place included, the Head of Occupational Therapy and the lead occupational therapist for The Orchard in the process of completing Postgraduate Diplomas in Sensory Integration. Positive behavioural support training was in place and led by the consultant psychologist. Environmental improvements included the building of a sensory room on Pearl, Melrose and Parkland wards. A sensory room had also been planned for the atrium area. The service was supported by a learning disability consultant, they provided education and co-produced training sessions and support to staff. The service was in the process of introducing Books Beyond Words onto each ward. All books were wordless picture stories and co-created by people with a learning disability or autism. An occupational therapist and activity co-ordinators had undertaken foundation training to introduce these books to the wards. All staff could access the Oliver McGowan Training on Learning Disability and Autism on the trust intranet. All medical staff and psychologists had been trained to assess for autism using Autism Diagnostic Observation Schedule (ADOS).

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Ward teams could access dieticians and speech and language therapists as required. These specialists worked with staff and patients to fully understand patients' nutrition and hydration needs. Care plans showed staff clarified with patients whether they had any dietary requirements related to their health or religion.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had a strong focus on health promotion and healthy living. The physical health team had introduced screening programmes for patients. This included cervical screening, breast screening, retinal (for patients with diabetes), chlamydia (for those aged 15-24 years) and bowel screening. Patients could access smoking cessation and exercise specialists. Patients could access gym facilities following a risk assessment. Additional funding had been secured for additional exercise advisors in for evenings and weekends.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers ensured staff carried out a range of audits to check that staff followed best practice guidance. For example, there were audits of care plans, consent to treatment documents, medicines, 132 rights and outcome measures. Managers reviewed the performance of the wards at monthly Clinical Improvement Group meetings. Audit results were used to identify where improvements were needed.

The physical health lead had carried out a quality improvement project on improving the referrals for external specialist advice and timeliness of appointments. This has helped speed up referrals and ensure they are accepted. On Aurora ward staff were undertaking a quality improvement project to improve the contact that patients had with their relatives/ carers. Where possible quality improvement initiatives were co-produced with patients.

Our findings

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. However, on Aurora ward the team had not had a psychologist since March 2022. The ward team were being supported by an assistant psychologist whilst recruitment took place. There were social worker vacancies on Pearl and Damson wards. There was ongoing recruitment to fill these posts. The service had also recruited four registered learning disability nurses to support ward teams.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff were positive about working for the service and informed us that there were opportunities for career progression and development within the service.

Managers gave each new member of staff a full induction to the service before they started work. Recently appointed staff told us they had been well supported and received a comprehensive induction before they started work on the wards.

Staff we spoke with confirmed they had access to regular clinical and managerial supervision. Staff reported that they used supervision to discuss the current patients, to reflect and learn from practice, incidents and for personal support and professional development. Staff supervision records reflected these discussions. Regular bank staff also received regular supervision if they wanted.

Managers made sure staff attended regular team meetings or gave information from those that could not attend. Where staff were unable to attend team meeting minutes were available. We reviewed team meeting minutes for each ward. These varied in quality of information provided, for example on Damson ward the minutes were very brief.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge including accessing specialist training for example staff on Aurora ward had undertaken training in British Sign Language.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multi-disciplinary meetings to discuss patients care, treatment and improve their care. All members of the multi-disciplinary team and staff worked together to understand and meet the range and complexity of patient's needs. We observed three multi-disciplinary team meetings, staff attended in person and shared clear information about patients, reviewed their care and treatment plans and took account of any changes in risks. We saw that the meetings were very thorough and included a holistic review of the individual needs of the patient.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Our findings

Ward teams had effective working relationships with other teams in the organisation. Staff regularly consulted with patients' care coordinators and other wards across the hospital.

Ward teams had effective working relationships with external teams and organisations. Staff worked closely with the local safeguarding team and patients' care coordinators in their local areas to facilitate effective discharge planning and follow-up care. The service worked with local universities to provide student placements.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

We carried out a Mental Health Act Review visit on Garnet ward during our inspection.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy (IMHA) and patients who lacked capacity were automatically referred to the service. Patients we spoke with confirmed that they could access the IMHA service on the ward provided by The Advocacy Project. The IMHA visited the wards weekly or in response to requests from patients. We were told that patients often requested the IMHA to attend ward rounds with them.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patients we spoke with on Garnet ward confirmed that they were regularly advised of their rights.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The records we viewed showed that leave was appropriately recorded including clear, specified conditions and escorting requirements. The patients with whom we spoke on Garnet ward understood their leave authorisation.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Our findings

Staff received, and were consistently up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interests of patients and considered the patient's wishes, feelings, culture and history. When a patient lacked capacity for a specific decision, staff said the multidisciplinary team, with the patient's input, would discuss the issue and make a decision in the patient's best interests that took into account the patient's wishes.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Is the service caring?

Inspected but not rated

We did not inspect the whole of the key question during this inspection. We found no evidence to suggest the existing rating of outstanding should be reviewed or changed.

Staff treated patients with compassion and kindness and valued them as partners. Patients told us that they were well looked after.

There was a strong person-centred culture. Staff were highly motivated and inspired to provide care that promoted and respected patients' privacy and dignity. They understood and valued the individual needs of patients and supported patients to understand, lead and manage their care, treatment or condition.

Patients received high quality care and support from a staff team that worked within a strong person-centred culture. There was a strong caring ethos throughout the service. Staff talked about valuing people, respecting their rights to make decisions, being inclusive and respecting people's diverse needs. Staff spoke about the patients with compassion and empathy.

Patients described staff being exemplary in ensuring their safety and providing emotional support, for example, some of the comments we received included 'They (staff) helped me build my confidence, 'Here we are listened to, we have a voice, we are not judged' and 'They respect my religion offering me space and privacy. During Ramadan staff provided food in the evening/night'.

We carried out two observation exercises on Parkland and Aurora wards. We saw that staff at all levels demonstrated professionalism, dignity, kindness and compassion when speaking with patients. Staff spoke to patients in a respectful tone and with warmth, giving them enough time to understand and respond. They asked questions that showed they were taking an interest in what patients were doing.

The service was exceptional at helping patients to express their views and being involved in the running of the service. For example, we saw that patients contributed to ward and divisional clinical improvement groups, all courses at the recovery college were co-produced and patients were involved in delivering induction training to new staff.

Our findings

Patients' individual differences were recognised and accommodated without judgement or discrimination. Reasonable adjustments were made, and care was tailored to individual needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Staff introduced patients to the ward and the service as part of their admission. A comprehensive welcome pack was available, and this provided information about the service.

Staff empowered patients to be active partners in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. Throughout our inspection we saw that patients were active partners in planning their care and risk management, for example on Melrose ward there was an advanced care plan agreed with a patient for when seclusion was required.

Care records demonstrated a strong patient voice. We saw and heard that patients' individual preferences and needs were reflected in how care was delivered, for example on Melrose ward during the multi-disciplinary team meeting we saw that the team considered feedback from relatives and the patient gave their own verbal feedback on how they were progressing during the meeting.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff understood and respected the individual needs of each patient for example on Aurora ward a British Sign Language interpreter attended meetings to support a patient with hearing impairment.

Involvement of patients

Staff supported patients to take an active role in decisions about the service, when appropriate. Patients met weekly on the wards with staff at the community meeting. These meetings were chaired by patients, this forum enabled patients to give feedback on the ward and raise any concerns.

The service had a strong focus on co-production. Each ward had service user representatives who were involved with various groups and meetings held about the service, such as reducing restrictive practices and clinical improvement groups. All courses at the recovery college are co-produced and co-facilitated by a member of staff and patient.

The practice development nursing team worked with a group of current patients who were part of the Helping Ordinary People Evolve (HOPE) team. The HOPE team consisted of a number of patients from within the inpatient and community forensic services, it was co-facilitated by a former user of the service. The team with support from staff promoted recovery and involvement within the service and wider trust, for example the team provided input into staff training such as PMVA. Patients within the HOPE team had been trained to be involved in staff interviews.

Patient representatives on each ward attended the ward clinical improvement group (CIG) meetings. Their views were considered, and they were involved in the discussions around team performance on the wards. There were also patient representatives at the divisional clinical improvement groups.

Our findings

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Family members and carers were involved as much as the individual patient wished them to be.

The service held a two monthly carers forum meeting where family members and carers could raise issues and concerns and provide feedback to the service. A separate carers forum was available for Black, Asian, Minority and Ethnic (BAME carers) which was led by the BAME transitional lead for the trust. There were no minutes kept for the main carers' forum. The BAME forum kept minutes which detailed any discussions and follow up action required. Eight of the carers we spoke with did not have awareness of the carers' forum.

Overall feedback from carers was positive about the care and treatment their family members received. They told us that their family members were safe and well looked after. Staff invited families and carers to attend Care Programme Approach (CPA) meetings to review patients' individual progress and support the patient. Families could provide feedback to staff directly at these meetings. We received some negative feedback from two carers regarding a lack of communication from ward staff. One carer reported not knowing when the carers forum was being held and being invited to care programme approach (CPA) meetings at short notice.

Is the service responsive?

Inspected but not rated

We did not inspect the whole of the key question during this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Patients followed a pathway through assessment, treatment, preparation for discharge and discharge. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Staff reported delays to discharge occurred when patients were referred on to other services and these referrals were not accepted. Staff within the service worked with other agencies including care coordinators to minimise the impact of delayed discharges and ensure patients were able to move on as necessary.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Our findings

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. A carer told us that the service had supported their daughter in successfully being moved to the community.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

Patients could personalise their bedrooms within the context of their individual risk assessments.

All wards had lockers for patients to store their possessions safely. Staff followed processes to manage security items such as razors, nail files and dental floss.

The service had a full range of rooms and equipment to support treatment and care. Each ward had a lounge, dining room and quiet room. Some wards also had occupational therapy kitchens so that patients could be supported to prepare their own food as part of their rehabilitation. Patients had access to an on-site library, gym, bank, hairdresser, shops, café, music and art therapy.

A visitor's room was available off the ward where patients could meet with visitors in private. All visits were booked in advance.

Patients could make phone calls in private. Each ward had a pay phone. Patients could use mobile phones on all the wards. These phones did not have access to the internet or cameras

The service had an outside space that patients could access easily.

The service offered a variety of food. Concerns regarding the quality of food were raised at the community meetings and feedback provided to the catering provider.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met patients' individual needs.

Patients could access interpreters, staff arranged either for an interpreter to be available in person or over the telephone. Interpreters attended ward rounds and Care Programme Approach (CPA) meetings as required. For example, on Aurora ward, interpreters and an interpreter in British Sign Language attended the ward round to support an individual patient.

Our findings

Some staff on Parkland and Melrose wards had been trained in the HOPE(S) method and in skills for working with women with autism and learning disabilities. Further training had been planned for February 2023. This is a clinical model of care to reduce long term segregation. The team on Parkland ward were supported by a specialist practitioner in this area.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room at the service which patients could access. Patients were supported by the spiritual and pastoral care team which consisted of chaplains from different faiths. They supported patients individually and visited the wards on a regular basis. The team also arranged visits from representatives from other faiths for patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service clearly displayed information about how to raise a concern in patient areas. Patients, relatives and carers knew how to complain or raise concerns. Advocacy support was available to patients if they wanted to make a complaint. Complaints could be raised with the staff on the wards, community meetings, service user forums, service user representatives and during one-to-one sessions.

All complaints were logged, tracked and reviewed at monthly ward clinical improvement groups and at the divisional clinical improvement group to ensure that learning took place. Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Inspected but not rated

We did not inspect the whole of the key question during this inspection. We found no evidence to suggest the existing rating of outstanding should be reviewed or changed.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders at all levels were very experienced and demonstrated they were knowledgeable, highly skilled and had the leadership abilities to ensure the service delivered excellent high-quality care. They had a detailed understanding of the services they managed and were visible in the service and approachable for patients and staff. There was compassionate, inclusive and effective leadership at all levels. Staff told us that the Chief Operating Officer for high secure and forensic services visited the service daily during the COVID-19 pandemic.

Ward managers were supported by the service director, deputy director of nursing and clinical lead for the service. Leaders knew the patients and staff well. Throughout our inspection we saw that patients were familiar and comfortable with the leadership team.

Our findings

Ward managers confirmed they had opportunities for development and had access to the trust's leadership development programmes. They also received peer support from other managers within the service.

Leaders were aware of the challenges with staffing, recruitment and retention and how this affected patients, staff morale and staff wellbeing on the wards.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The service had a caring, positive, open and inclusive culture which centred on improving the quality of care patients received through, compassion empowerment, partnership and involvement.

Staff were proud of the organisation as a place to work and spoke highly of the of the person-centred culture. Staff felt positive about their work and what they were managing to achieve within the staffing constraints. Staff at all levels were committed to ensuring that patients were at the heart of the service. Ward teams worked well together and supported each other.

Staff told us they were encouraged to share their views and could raise any concerns without fear of victimisation. They felt their views and opinions would be listened to.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression, for example the ward manager on Parkland ward was being supported to undertake a masters degree. Nursing associates were supported to undertake their nurse training. The service provided a comprehensive preceptorship programme for newly qualified nurses. Following the staff survey in March 2020, a high number of staff reported that they had experienced racial abuse from patients and their relatives. As a result, the service had run a series of focus groups with staff and patients to improve understanding and awareness about the impact of racism. The service had developed a booklet called 'respecting our differences'. This was now given to patients and their families.

Staff were confident in having positive conservations about career development and receiving full support from their managers.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Our findings from the other key questions demonstrated that the leadership, culture and robust governance processes were used to drive and improve the delivery of high quality, person centred care.

Managers ensured that there were clear governance and performance monitoring arrangements in place to support the delivery of the service, identified risk and monitored the quality and safety of service provision to provide high quality care to patients. There were systems and procedures to ensure that the wards were clean and safe. Environmental works were taking place, including the building of sensory rooms. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Concerns regarding staffing levels and skill mix were reported.

Our findings

Leaders were aware of areas where improvements could be made and were committed to improving care and treatment for patients and working environment for staff. For example, leaders told us they had escalated concerns regarding the lack of police action when a staff member had been assaulted by a patient. The service had escalated this to chief executive level and the head of the Metropolitan Police force.

The service held a range of meetings at which it shared issues and concerns, identified actions and monitored progress. These enabled staff to be kept updated about the service, incidents, safeguarding, complaints and essential information through patient community meetings, daily handover, team meetings, ward rounds, multi-disciplinary team and clinical improvement group meetings.

Staff were clear about lines of accountability, their roles, responsibilities and they understood the management structure within the service. Staff received appropriate mandatory, specialist training and supervision.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. There was a robust system for identifying, recording and managing risks, issues and mitigating actions. Risk management was embedded throughout the service and recognised as a collective responsibility of all the staff. Staff discussed risk daily through the safety huddles, handover meetings and multi-disciplinary team meetings to ensure that patients were safe.

Clinical teams had a good understanding of individual patient risks and were able to discuss any changes to patients' care or new insights into their presentation at the daily handover. There were systems in place to monitor risks associated with patients' physical health and any issues were quickly picked up and addressed.

The ward managers did not maintain ward-level risk registers, however, the managers on each of the wards were aware of the risks relevant to their ward and could escalate risks to the service risk register. Risk concerns were discussed at the directorate clinical improvement group and escalated, through the service line to board level, if necessary.

Regular audits were carried out and action plans developed where shortfalls had been identified. The audits ensured that quality was reviewed frequently, and systems were in place to identify and address any gaps in the delivery of safe care.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. Each ward manager could access a dashboard that held key data about the service. This included key information such as incident reporting, staffing, sickness, complaints and training.

Staff made notifications to external bodies as needed. This included notifications to CQC when a detained patient went absent without leave and when a detained patient died.

Our findings

The service had plans for emergencies. Staff spoke about the business continuity plans they had implemented because of the COVID-19 pandemic. Throughout the pandemic senior leaders attended the trust-wide Gold and Silver command meetings.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives.

The service was part of the North London Forensic Collaborative and strongly engaged with local health and social care partners to share best practice, promote quality improvement and to ensure that patients have a positive experience of care.

Staff received regular information about the trust and the service through the trust intranet, bulletins and emails. The service held two monthly staff forum meetings which gave staff opportunity to give feedback on the service.

Co-production involving patients was deeply embedded in the culture of the service and patients were involved in decisions and consulted about proposed changes to the service.

Our findings

Outstanding practice

We found the following outstanding practice:

- Patients were empowered as partners in their care and service development. We saw numerous examples of co-production with staff training in reducing restrictive practice, blanket restrictions, staff induction and learning disability training. An information guide on racism and its effect on staff and patients had been co-produced following feedback from the staff survey.

Areas for improvement

MUSTS

Forensic inpatient or secure wards

- The trust must ensure that staff do not complete intermittent observations at regular, predictable intervals. Regulation 12 (1)(b)

SHOULDS

Forensic inpatient or secure wards

- The trust should ensure that staff on all wards are involved in emergency simulation exercises.
- The trust should ensure that the bathroom in the seclusion suite on Garnet ward is routinely accessible.
- The trust should ensure that the procedure in place for opening the bathroom door in the Garnet ward seclusion suite is safe for both staff and patients.
- The trust should continue to address the high number of nursing vacancies in the service through active recruitment and retention strategies.
- The trust should ensure that all medicine incidents are reported in line with the trust policy.
- The trust should ensure that long-term segregation (LTS) care plans clearly detail how LTS will be bought to an end, clearly record patient involvement and refer to recommendations made from external reviews.
- The trust should ensure that the quality of information in team meeting minutes is improved.
- The trust should consider incorporating learning from incidents as a regular agenda item for team meetings.
- The trust should ensure that all carers are provided with information on the carers' forum.
- The trust should ensure that minutes are kept of the carers' meetings.

Our inspection team

The team that inspected the hospital comprised a CQC lead inspector, one inspector, one pharmacist inspector, two inspection managers, one Mental Health Act reviewer, one expert by experience and one specialist professional advisor who had experience of working in forensic services.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment