Cygnet Health Care Limited

Forensic inpatient/secure wards

Quality Report

Cygnet Hospital Stevenage
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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)
1-130486821	Cygnet Hospital Stevenage	Saunders Tiffany Peplau and Pattison wards	SG1 4YS

This report describes our judgement of the quality of care provided within this core service by Cygnet Health Care Limited. 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 Cygnet Health Care Limited and these are brought together to inform our overall judgement of Cygnet Health Care Limited.

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

Contents

Summary of findings

Overall summary

- Identified risks were being managed appropriately. For example, the fixtures and fittings associated with curtain rails have been changed across the hospital to reduce any potential self-ligature risk. Most patients felt safe on the wards and told us that staff reacted promptly to any identified concerns.
- We reviewed the current and previous staff rotas and these showed us that there was enough staff on duty to meet the needs of the patients on both wards. Additional staff had been rostered to meet the need for enhanced staffing due to assessed patient need.
- Assessments took place using a nationally recognised risk assessment tool; the historical current risks 20 framework. Outcomes were being monitored using the health of the nation outcome scales. Patients were receiving cognitive analytical therapy and dialectical behaviour therapy (DBT).This was being provided in four modules as group therapy. Self-reported and other outcome measures were being documented. The length of stay on these wards ranged from six months to four years.
- Staff received training via a monthly mandatory training week. Most staff reported receiving effective training opportunities.
- Different professions worked effectively to assess and plan care and treatment programmes for patients. The wards had a dedicated social worker and they liaised closely with patients' families and with statutory agencies as applicable.
- We saw good examples of effective staff and patient interaction and individual support being provided.
- The provider had a clear complaints policy and procedure systems for them to be investigated and complainants to be given a response.
- Most staff were aware of the provider's vision and values. Senior hospital managers had access to governance systems that enabled them to monitor the quality of care provided. This included the provider's electronic incident reporting system, corporate and unit based audits and electronic staff training record. Senior staff were visible throughout the hospital and staff approached them to raise concerns.

However:

- We found examples of poor practice in relation to restrictive practices. Staff did not record incidents of seclusion and restraint in a consistent manner. Some seclusion records were inconsistent and difficult to follow. There was inappropriate use of segregation in some cases. Staff sometimes recorded food and fluid intake inconsistently whilst patients were in segregation.
- A number of care plans had not been consistently reviewed and updated to reflect changes in assessed risk levels. Individual assessment and treatment records seen did not always demonstrate an involvement in their care and treatment by all patients. The reasons for this were not clearly recorded.
- Training records for agency staff were difficult to review. Often the main agency of choice subcontracted to other agencies to provide staff for the hospital and this meant that the provider could not be assured of the level of training provided to all agency staff.
- Across all four wards we noted that patients were subjected to blanket restrictions and that not all of these had been subject to a clear risk assessment.
- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes. This meant that staff worked longer that their allocated shift time in order to ensure a comprehensive handover took place.

Summary of findings

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

Are services safe?

- We saw a ligature audit risk assessment of the hospital dated February 2013 and this was monitored monthly through the corporate health and safety department. Identified risks were being managed appropriately throughout the hospital. For example, the fixtures and fittings associated with curtain rails have been changed to reduce any potential self-ligature risk. Most patients felt safe on the wards and told us that staff reacted promptly to any identified concerns.
- We reviewed the current and previous staff rotas and these showed us that there was enough staff on duty to meet the needs of the patients on both wards. Additional staff had been rostered to meet the need for enhanced staffing due to assessed patient need.
- Each patient had an individualised risk assessment and these had been reviewed by the multi-disciplinary team. Actions identified from incident reviews were being followed up. Evidence was seen of this both at ward level and via the monthly clinical governance meetings.

However:

- We found examples of poor practice in relation to restrictive practices. Staff did not record incidents of seclusion and restraint in a consistent manner. Some seclusion records were inconsistent and difficult to follow. There was inappropriate use of segregation in some cases. Staff sometimes recorded food and fluid intake inconsistently whilst patients were in segregation.
- Staff told us that ward based staff meetings across the hospital were often postponed due to pressures of work.

Are services effective?

- Assessments took place using a nationally recognised risk assessment tool; the historical current risks 20 framework. Outcomes were being monitored using the health of the nation outcome scales. Patients were receiving cognitive analytical therapy (CAT), cognitive behavioural therapy and dialectical behaviour therapy. This was being provided in four modules as group therapy. Self-reported and other outcome measures were being documented. Patients had multi-disciplinary assessments in place.
- A physical health care facilitator was employed by the hospital.
- Staff received training via a monthly mandatory training week.

Summary of findings

However:

- A number of care plans had not been consistently reviewed and updated to reflect changes in assessed risk levels. Individual assessment and treatment records seen did not always demonstrate an involvement in their care and treatment by all patients. The reasons for this were not clearly recorded.
- Training records for agency staff were difficult to review. Often the main agency of choice subcontracted to other agencies to provide staff for the hospital and this meant that the provider could not be assured of the level of training provided to all agency staff.
- Gaps were noted in the recording of patients being informed of their rights under the Act. Some gaps were noted in the completion of T2 and T3 treatment medication records.

Are services caring?

- Most patients were positive about the support which they received on each ward. Staff explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the needs of patients on this unit.
- Community meetings were held on the wards. The hospital had a service user involvement forum that met every month as well as regular joint planning meetings for the organisation and co-ordination of hospital events
- Six monthly family days were organised. The next one was due in February 2015. We saw effective social worker liaison with families.

However:

- Three patients raised concerns about the engagement of night staff with them.
- Individual assessment and treatment records reviewed did not demonstrate an involvement in their care and treatment by all patients and the reasons for this were not clearly recorded.

Are services responsive to people's needs?

- Clear assessments were carried out by the multi-disciplinary team prior to admission. There was a pro-active psychology department delivering some positive and innovative group therapy sessions for patients.
- The wards had a dedicated social worker and they liaised closely with patients' families and with statutory agencies as applicable. However, patients' discharges could be delayed due to difficulties in finding suitable future placements.

Summary of findings

- We saw that patients had a high level of community access supported by staff wherever possible. Some patients worked in the hospital shop and this enabled people who did not have community access to engage in therapeutic activity. Educational sessions such as maths, English and CV writing were provided. Examples were seen of advocacy support during clinical reviews where required.
- The provider had a clear complaints policy and procedures in place for them to be investigated and complainants to be given a response.

However:

- Across all four wards we noted that patients were subjected to blanket restrictions and that not all of these had been subject to a clear risk assessment.
- Gaps were seen in the provision of complaint response letters to individual patients.

Are services well-led?

- Most staff across the hospital were aware of the provider's vision and values. Senior hospital managers were visible to front line staff and patients. Staff in particular non-clinical staff spoke highly of the provider's vision and values.
- Senior hospital managers had access to governance systems that enabled them to monitor the quality of care provided. This included the provider's electronic incident reporting system, corporate and unit based audits and electronic staff training record.
- Systems were in place to gain the views of staff and patients. We saw evidence of actions taken in response to these. For example, 'you said and we did'.
- Key performance indicators were discussed at the provider's monthly clinical governance meeting. For example, safeguarding, incidents and complaints.

However:

- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes. This meant that staff worked longer that their allocated shift time in order to ensure a comprehensive handover took place.
- Some hospital staff felt that there was a disconnect between the provider's vision and values and the actions of some senior staff.

Summary of findings

- Hospital staff reported concerns with the actual reward package received compared to the advertised package upon recruitment.

Summary of findings

Background to the service

Cygnet Hospital Stevenage is a purpose built hospital providing assessment and treatment to in-patients. It is located on the outskirts of Stevenage.

There were four forensic and secure inpatient wards at this hospital.

Pattison ward – 14 beds female medium secure with 13 in-patients at the time of inspection.

Peplau ward – 14 beds male medium secure with 13 in-patients at the time of inspection.

Saunders ward - 15 beds male low secure with 15 in-patients at the time of inspection.

Tiffany ward - 15 beds female low secure with 13 in-patients at the time of inspection.

There were 54 in-patients receiving assessment and treatment in this core service during our inspection.

Each patient was detained under the 1983 Mental Health Act and some were subject to additional restrictions imposed by the Ministry of Justice.

Average bed occupancy over the past six months had ranged from 80 – 95% and admissions were managed in conjunction with specialist commissioning arrangements with NHS England.

The location was last inspected by the Care Quality Commission on 29 November 2013 and there were no regulatory breaches identified.

Our inspection team

Our inspection team was led by:

Inspection managers**: Lyn Critchley and Peter Johnson (mental Health) CQC**

The team that inspected this location comprised of:

- Two CQC hospital inspection managers.
- Three specialist advisors; a consultant psychiatrist, a psychologist and a senior mental health nurse.
- Three Mental Health Act reviewers.
- Two experts by experience that had experience of using mental health services.

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 get to the heart of 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 inspecting this hospital, we reviewed information which was sent to us by the provider and considered feedback from relevant local stakeholders including advocacy services.

There were two core services being provided within one hospital. These are managed by the same senior management team. We have produced two reports to reflect this.

During the inspection visit the inspection team:

Summary of findings

- Visited all four wards and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with eighteen patients across the wards.
- Interviewed the ward managers for each ward.
- Spoke with senior hospital managers accountable and responsible for this core service. This included the interim hospital director, registered manager,newly appointed hospital director and the corporate quality assurance manager.
- Spoke with the medical director, two consultant psychiatrists and two associate specialists.
- Spoke with sixteen frontline staff members including allied healthcare professionals, trained nurses and health care assistants.
- Held six focus groups which thirty-five staff from across the whole hospital attended.

We also:

- Reviewed in detail 21 individual assessment and treatment records
- Reviewed 30 prescription charts.
- Examined 18 legal records in relation to people's detention under the Mental Health Act 1983.
- Looked at a range of policies, procedures and other records relating to the running of this service.

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

What people who use the provider's services say

During the inspection the inspection team

- Spoke with 18 patients across the wards.
- Reviewed the comment cards supplied by the Care Quality Commission that eight patients had completed..
- Reviewed the provider's quality monitoring systems such as patient surveys.
- Spoke with six family members and carers by telephone with their prior agreement.

Patients told us that they usually felt safe on the unit and received good treatment. They told us that there were enough staff on duty and that staff were responsive when concerns were raised. Patients knew who their primary nurse was and felt able to talk to them. They told us that they felt involved in their individual care and that they met with their doctor regularly.

Good practice

- Some patients worked in the hospital shop and this enabled people who did not have community access to engage in therapeutic activity.
- Patients had a high level of community access supported by staff where required.
- There was a pro-active psychology department delivering some positive and innovative cognitive analytical and dialectical behaviour group therapy sessions for patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- The provider must review their existing recording system for seclusion, segregation and restraint episodes.
- The provider must ensure that every care plan is evaluated to reflect changes to assessed risk levels.

Summary of findings

- The provider must ensure that the systems in place to monitor agency staff training also includes the monitoring of the training of staff engaged through sub-contracted agencies.

Action the provider SHOULD take to improve:

- The provider should ensure that the time allocated for handover between staff shifts is reviewed.
- The provider should ensure that the reasons for non-involvement in their care and treatment by patients is documented clearly.
- The provider should review all of their restrictive practices on these wards and ensure that any remaining restrictions in place are based on a clear assessment of patient risk.

Cygnet Health Care Limited

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Saunders Tiffany Peplau and Pattison wards	Cygnet Hospital Stevenage

Mental Health Act responsibilities

- 66% of staff across the hospital had received their mandatory MHA training for 2014/2015. Gaps were noted in the recording of patients being informed of their rights under the Act. Some gaps were noted in the completion of T2 and T3 certificate of treatment records.

The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice. Information regarding patient rights under the Act were on display. Patients were aware of the independent advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that people's mental capacity to consent to their care and treatment had been assessed where relevant. 66% of staff across the hospital had received their refresher training for 2014/2015.

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

Summary of findings

Our findings

Cygnet Hospital Stevenage – Saunders Tiffany Peplau and Pattison wards

Safe and clean ward environment

- The ward layouts enabled staff to observe patients effectively. Enhanced observation records were completed well. Relational security arrangements were in place when patients accessed the hospital's smoking areas. We saw a ligature audit risk assessment of the hospital dated February 2013 and this was being monitored monthly through the corporate health and safety department. Identified risks were being managed appropriately. For example, the fixtures and fittings associated with curtain rails have been changed throughout the hospital to reduce any potential self-ligature risk.
- The wards were generally well maintained. Staff told us that maintenance requests were promptly addressed where ever possible. Arrangements were in place to support visits by external contractors. Patients told us that domestic staff worked hard to keep the wards clean. Dedicated cleaners were employed by the hospital. However, parts of the wards required a deep clean by specialist cleaners. For example the sinks and plug holes in clinic rooms.
- Resuscitation equipment was in place and checked regularly to ensure that it was fit for purpose and could be used in an emergency situation.

Safe staffing

- We reviewed the current and previous staff rotas over the past three months and these showed us that there was enough staff on duty to meet the needs of patients. Some patients were on enhanced observation levels following clear risk assessments. We noted that where gaps had been identified within the duty rotas this was being covered by the use of bank and agency staff. Additional staff had been rostered to meet the need for enhanced staffing due to assessed patient need. These staff were booked directly by the ward manager or by the shift co-ordinator out of core hours. Senior managers informed us that they provided additional support through an 'on call' system and worked ward based shifts if needed. This was supported by those duty rotas reviewed. The hospital had its own bank of qualified and support workers. Agency staff are also used. New permanent, bank and agency staff received an induction to the hospital.
- Pattison ward had a staff vacancy rate of 18.75% and Peplau a staff vacancy rate of 9.70%. Tiffany ward had a staff vacancy rate of 5.50% and Saunders ward a staff vacancy rate of 11.80%.
- Average bed occupancy was 13 for Peplau and Pattison wards. 12 for Saunders and 14 for Tiffany wards.
- Permanent staff sickness rates were Peplau – 3% and for Pattison – 4.5%. Saunders – 2.3% and for Tiffany – 3%. This was below the national average of 5% for similar mental health services.
- An active recruitment programme was under way. This was supported by the evidence seen in the local press and on the provider's web site.
- There was no evidence seen of staffing levels having an impact on activity provision or access to Section 17 leave.
- Senior managers confirmed that retention and recruitment of staff was a concern. Staff told us that ward based staff meetings were often postponed due to pressures of work. The lack of an acuity tool to establish staffing levels meant that concerns were identified regarding baseline staffing levels on Tiffany and Pattison wards.

Assessing and managing risks to patients and staff

- 48 episodes of long term segregation and seclusion were reported for the four wards between July and December 2014. These were closely monitored and audited by the hospital. However, some seclusion records were inconsistent and difficult to follow. For example, there was inconsistent and duplicate recording in both seclusion records and assessment and treatment records. Examples were seen of inconsistent recording of restraint episodes in some of those restraint records reviewed. Evidence was seen of the

Are services safe?

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

inappropriate use of segregation in some cases. For example, one person had been in long term segregation without evidence of a clear review of the need for this. This had subsequently been addressed by the provider. Some examples were seen of inconsistent recording of food and fluid intake whilst patients were in segregation. For example, the recording of the provision of food and fluids for a patient with diabetes whilst they were in segregation was incomplete.

- Most patients felt safe on the wards and told us that staff reacted promptly to any identified concerns. Each patient had an individualised risk assessment and these had been reviewed by the multi-disciplinary team. Risk assessments took into account historic risks and identified where additional support was required. These assessments had been updated to reflect assessed changes in clinical need.
- Staff across the hospital had received safeguarding training. We found that staff were attending their annual refresher training. They were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly. They knew who the hospital's safeguarding lead was. Safeguarding incidents had been reported through the provider's safeguarding protocols and where required had been investigated appropriately. The hospital had informed the Care Quality Commission of each safeguarding incident identified.
- Staff knew how to report incidents and the provider had clear guidance to staff on incident reporting. All serious untoward incidents were reviewed daily by senior hospital managers.
- 158 incidents of the use of restraint; 68 of which had some elements of prone restraint were reported by the hospital between July and December 2014. None of these had resulted in a serious incident being recorded. Senior managers confirmed that the use of prone restraints was under review in line with the guidance issued by the Department of Health.

Track record on safety

- There was a clear risk management strategy dated October 2014.The provider reported 34 serious incidents across this hospital that had required investigation since January 2014. 20 of these related to incidents between patients. The frequency of these had reduced recently. Evidence was seen that these had been investigated appropriately in line with the provider's policy and procedures.
- The provider had reported any notifiable incidents appropriately to the Care Quality Commission as required by the relevant regulations.

Reporting incidents and learning from when things go wrong

- Staff knew how to report any incidents on the provider's electronic reporting system. Senior staff were aware of incidents and these had been discussed daily and escalated appropriately for action. For example by making a safeguarding referral. . Post incident debriefing was available for patients and staff and we saw examples of these. Actions identified from incident reviews were being followed up. Evidence was seen of this both at ward level and via the monthly clinical governance meetings. Staff told us that they received feedback about the outcome of incidents that had happened. The hospital had 24 hour receptionist cover based on lessons learnt from incidents that happened at night.

Are services effective?

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.

Summary of findings

Our findings

Cygnet Hospital Stevenage – Saunders Tiffany Peplau and Pattison wards

Assessment of needs and planning of care

- Patients had multi-disciplinary assessments in place. This included care plans and personal support plans. Physical healthcare monitoring was taking place for example of a patient with diabetes. A physical health care facilitator was employed by the hospital.
- A number of care plans examined had not been consistently reviewed and updated to reflect changes in assessed risk levels.

Best practice in treatment and care

- Assessments took place using the using the historic current risks 20 and outcomes were monitored using the health of the nation outcome scales. Staff had identified any concerns with physical healthcare and short term care plans were in place to support these.
- The wards had access to dedicated social workers and psychologists to improve care and treatment outcomes. Patients attended GP, dentists and other health appointments when required. Weekly general practitioner consultations took place in the hospital for those people who were unable to access the community. Some patients worked in the hospital shop and this enabled people who did not have community access to engage in therapeutic activity.
- Staff provided a range of therapeutic interventions in line with the guidance issued by the National Institute for Health and Care Excellence. These included 121 therapy and group therapy being provided by the psychology team. Patients were receiving cognitive analytical therapy and dialectical behaviour therapy. This was being provided in four modules as group therapy. The hospital used the 'Kentucky mindfulness' model. Self-reported and other outcome measures were being documented. Records were seen of steps being taken to manage non –engagement of patients with therapy.
- The wards across the hospital were visited weekly by an external pharmacy provider under a service level agreement. Regular medicine audits were being carried out and the hospital had taken action to address any identified concerns. However, medication stock audits were not assessed by staff against the medicine administration record sheets.

Skilled staff to deliver care

- Staff reported receiving effective training opportunities. Staff received training via a monthly mandatory training week. 100% of staff were on target to complete their annual mandatory training programme. Staff were incentivised to complete this. Some staff had received external funding to allow them to additional role specific training. For example mindfulness and leadership courses. New staff had an induction programme prior to working on the unit. Non-attendance was monitored and reported to line managers. Monthly training attendance was reported to senior management. However, training records for agency staff were difficult to review. Often the main agency of choice subcontracted to other agencies to provide staff for the hospital and this meant that the provider could not be assured of the level of training provided to all agency staff.

Multi-disciplinary and intra-agency team work

- Different professions worked effectively to assess and plan care and treatment programmes for patients. The ward team comprised a consultant psychiatrist, ward doctor, psychology, and occupational therapy, social work supported by housekeeping, catering, maintenance and administration. Evidence was seen of collaborative working with patients' home areas as required. Staff across the hospital reported positive links with a local police liaison officer who would visit to meet patients or staff if required

Adherence to the MHA and MHA code of practice

- 66% of staff had received their mandatory MHA training for 2014/2015. Gaps were noted in the recording of patients being informed of their rights under the Act. Some gaps were noted in the completion of T2 and T3 certificate of treatment records. Patients were aware of the independent advocacy service. The provider had

Are services effective?

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.

clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice. Information regarding patient rights under the Act was on display.

Good practice in applying the MCA

- The provider had systems in place to assess and record people's mental capacity to make decisions and had developed care plans for this where applicable. 66% of staff had received their refresher training for 2014/2015.

Are services caring?

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

Summary of findings

Our findings

Cygnet Hospital Stevenage – Saunders Tiffany Peplau and Pattison wards

Kindness dignity respect and support

- Most patients were positive about the support which they received on each ward. We saw good examples of effective staff and patient interaction and individual support being provided. Staff treated patients with kindness and respect and patients confirmed this. Staff explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the needs of patients on this unit. However, three patients raised concerns about the engagement of night staff with them. This was brought to the attention of senior managers who agreed to look into these concerns

The involvement of people in the care they receive

- Patients told us that staff involved them in their own care. They were seen regularly by their responsible clinician and that if they had questions about their medication staff would answer these. Community meetings were held on the wards. The hospital had a service user involvement forum that met every month as well as regular joint planning meetings for the organisation and co-ordination of hospital events. Advocates were available across the hospital and there was information available about access to advocacy services. The hospital had produced a 'welcome pack' for patients who were admitted to help orientate them to the hospital. Six monthly family days were organised. The next one was due in February 2015. We saw effective social worker liaison with families.
- We found that seven assessment and treatment records reviewed did not demonstrate an involvement in their care and treatment by the patient concerned. For example discussions regarding individual care plans were not recorded.

Are services responsive to people's needs?

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

Summary of findings

Our findings

Cygnet Hospital Stevenage – Saunders Tiffany Peplau and Pattison wards

Access discharge and bed management

- Clear assessments were carried out by the multi-disciplinary team prior to admission. Regular contract monitoring meetings took place with NHS England and other commissioners. Enhanced care programme approach (CPA) meetings were held. The wards had a dedicated social worker and they liaised closely with patients' families and with statutory agencies as applicable. Patients' discharges could be delayed due to difficulties in finding suitable future placements. There had been three delayed discharges on Peplau ward and one on Saunders ward between July and December 2014. The length of stay on these wards ranged from six months to four years. Bed occupancy on these units ranged from 80% on Saunders ward to 95% on Peplau ward.

The ward optimises recovery comfort and dignity

- Access to Mental Health Act section 17 leave was documented. This included when leave was cancelled. We saw that patients had a high level of community access supported by staff wherever possible. Clear arrangements were in place to facilitate family visits to the unit. Patients had access to a courtyard and a smoking shelter.
- Across all four wards we noted that patients were subjected to blanket restrictions and that not all of these had been subject to a clear risk assessment. This included the use of plastic cutlery on Pattison ward.

Meeting the needs of all the people who use the service

- The wards had a dedicated social worker and they liaised closely with patients' families and with statutory agencies as applicable.
- Occupational therapy was being provided and we saw that patients were encouraged to participate in their weekly activity programme. Educational sessions such as maths, English and CV writing were provided. Access to ward facilities across the hospital such as the laundry and ward based kitchen were risk assessed.
- Patients' diverse needs such as religion and ethnicity were recorded and these were being met across the hospital for example through religious specific diets. Most patients told us that the food provided was good and they were given a choice.
- There was information available throughout the service for patients and this included information about rights under the Mental Health Act. Examples were seen of advocacy support during clinical reviews where required.

Listening and learning from concerns and complaints

- Information was displayed on each ward for patients to provide them with information about making a complaint. The provider had a clear complaints policy and procedure systems for them to be investigated and complainants to be given a response. There were additional systems for patients to raise issues at the ward based community meetings and at the monthly 'service user' forum. Staff told us that complaints were discussed at senior managers meetings and this was supported by those minutes seen. Learning from complaints was disseminated. For example via the hospital's weekly newsletter. However, we found inconsistencies in the provision of complaint outcome letters to some patients in line with the provider's own complaint policy and procedure.

Are services well-led?

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.

Summary of findings

Our findings

Cygnet Hospital Stevenage – Saunders Tiffany Peplau and Pattison wards

Vision and values

- Most staff across the hospital were aware of the provider's vision and values. Staff were given a key ring with these values on. Senior managers were visible to front line staff and patients throughout the hospital. Staff had access to the provider's intranet and received a weekly hospital newsletter. Senior hospital staff had attended provider away days to discuss the vision and values of the organisation. Recruitment interviews and appraisals both make reference to the provider's vision and values. Staff in particular non-clinical staff spoke highly of the provider's vision and values. However, some staff felt that there was a disconnect between the provider's vision and values and the actions of some senior staff.

Good governance

- Senior hospital managers had access to governance systems that enabled them to monitor the quality of care provided across the hospital. This included the provider's electronic incident reporting system, corporate and unit based audits and electronic staff training record. Monthly clinical hospital wide governance meetings took place. The minutes showed us that these were comprehensive and any actions arising were being addressed. Learning from incidents and complaints were disseminated via the hospital's weekly newsletter. Senior managers monitored staff training attendance. Staff had annual appraisals and received regular supervision. The hospital used a supervision matrix to identify any potential gaps in these.

Leadership morale and staff engagement

- Staff reported good morale and positive peer support. Front line staff told us that their line manager was supportive and provided clear guidance. There was an employee assistance programme across the service and staff had access to external counselling if required. Systems were in place to gain the views of staff and patients. We saw evidence of actions taken in response to these. For example, in minutes following community meetings.
- Senior staff were visible in the service and examples were seen of staff approaching them to raise concerns. The provider had a system to allow staff to raise any concerns confidentially. The provider had introduced a new escalation policy for staff to raise issues. Evidence was seen that regular unannounced visits took place by executive directors. The newly appointed chief executive officer rotated board meetings around the hospital sites to increase the visibility of senior leaders.
- Some staff reported concerns with the actual reward package received compared to the advertised package upon recruitment.
- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes. This meant that staff worked longer that their allocated shift time in order to ensure a comprehensive handover took place.

Commitment to quality improvement and innovation

- Key performance indicators were discussed at the trust's monthly clinical governance meeting. For example, safeguarding, incidents and complaints. Evidence was seen that regular unannounced visits took place by senior managers. These included night visits.
- Senior managers confirmed that these four wards were preparing to participate in the quality network for forensic Mental Health services.
- There was a pro-active psychology department delivering some positive and innovative group therapy sessions for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found that the provider had not protected patients against the inappropriate recording of seclusion, segregation and restraint episodes. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of – Where any form of control or restraint is used in the carrying out of the regulated activity. The registered person must have siuitable arrangements in place to protect service users against the risk of such control or restraint being:- (a) Unlawful or, (b) Otherwise excessive The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 11 (2)(a)(b). And – 13 (4) Care or treatment for service users must not be provided in a way that— 1. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 13 (4)(a).

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found that the provider had not protected patients against the inappropriate recording of seclusion, segregation and restraint episodes. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of – Where any form of control or restraint is used in the carrying out of the regulated activity. The registered person must have siuitable arrangements in place to protect service users against the risk of such control or restraint being:- (a) Unlawful or, (b) Otherwise excessive The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 11 (2)(a)(b). And – 13 (4) Care or treatment for service users must not be provided in a way that— 1. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 13 (4)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Requirement notices

We found that the provider had not protected patients by ensuring that the monitoring of agency staff training also included the monitoring of the training of staff engaged through sub-contracted agencies. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In order to safeguard the health, safety and welfare of service users, the trust must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation (22).

And –

1)Persons employed by the service provider in the provision of a regulated activity must—

1. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **We found that the provider had not protected patients by ensuring that all care plans were evaluated and reviewed to reflect changes to assessed risk levels. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Requirement notices

The provider must take proper steps to ensure that each person is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the person's individual needs, and to ensure the welfare and safety of the person.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (9)(1)(b)(i)(ii).

And –

9

1)The care and treatment of service users must—

1. A. be appropriate,
   B. meet their needs

3)

1. C. carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

12.—

1. Care and treatment must be provided in a safe way for service users.
2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—
   A. assessing the risks to the health and safety of service users of receiving the care or treatment;
   B. doing all that is reasonably practicable to mitigate any such risks

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 9 (1)(a)(b)3(c) and 12 (1)(2)(a)(b).