Elysium Healthcare (Acorn Care) Limited

Moorlands Neurological Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

This was a focused follow-up inspection of Moorlands Neurological Centre, previously known as The Woodhouse Independent Hospital. At the time of our inspection, Moorlands Neurological Centre continued to provide a service to people with a learning disability or autism. We carried out this inspection to follow up on enforcement action we issued at our most recent inspection in February 2022, where we asked the provider to make significant improvement to its services.

In February 2022, our inspection of The Woodhouse Independent Hospital identified significant concerns that rated the service inadequate and applied Special Measures.

Since that inspection, the provider had commenced transformation of the hospital from one that provided a service to people with a learning disability or autism to one that provided a service to patients with an acquired brain injury. However, although the name of the hospital had changed, patients with an acquired brain injury had not yet been admitted.

Because this inspection focused only on the concerns raised at our previous inspection and the Warning Notice issued following it, we did not change our rating.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The previous rating of inadequate remains because we did not have enough evidence to rerate the key questions of safe and well led. We found:

The provider continued to identify incidents where some staff did not always follow plans or use approved physical interventions with people who used the service during incidents or to manage behaviour that challenged.

The provider continued to identify incidents where some staff failed to identify and escalate abuse or improper treatment of people who used the service.

The provider remained challenged to ensure staff always accurately reported and recorded incidents that occurred in the service. It was not clear staff always used sharing of lessons learned following incidents to prevent similar incidents occurring again.

However:

The provider had implemented service transformation plans that meant people with a learning disability or autism would no longer be supported at the service. Feedback from commissioners on the implementation of the plan was positive.

Summary of findings

We saw improvement in governance processes to ensure safety and quality in the service through monitoring of closed circuit television camera (CCTV) footage and incidents. This allowed managers to quickly identify and respond to concerns about the conduct or practice of staff with people who used the service.

The provider had taken action to support speaking up in the service. There was improvement in the number of staff speaking up with concerns related to safeguarding or culture in the service.

The experience of staff of leaders in the service continued to be positive. Plans to transform the service had been communicated well, staff felt well informed and supported during the process.

The provider had improved clinical areas in preparation for patients with an acquired brain injury. They had retained enough staff to safely meet the initial implementation of the new service model and supported staff to develop skills to work with the new patient group.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Moorlands Neurological Centre

Moorlands Neurological Centre, previously The Woodhouse Independent Hospital, is an independent mental health hospital provided by Elysium Healthcare (Acorn Care) Limited. As The Woodhouse Independent Hospital, it provided services for people with a learning disability or autistic people. The service specialised in providing care for autistic people and people with forensic histories including; sexual offending, highly complex and severe challenging behaviour.

We previously inspected the service in February 2022. This inspection was carried out to follow-up concerns from our June 2021 inspection that gave The Woodhouse Independent Hospital an overall rating of 'requires improvement' and rated the safe domain as 'inadequate'. Our findings were as follows:

We found that staff did not always use recognised interventions and approved physical intervention techniques to manage incidents and behaviour that challenged with people who used the service.

We found that staff present but not directly involved in incidents where colleagues illtreated people in their care, had failed to identify and escalate concern in what they had observed.

We found that not all governance systems were sufficiently robust or always worked effectively to ensure safety and quality in the service. Staff did not report all incidents in the service and not all incidents reported were an accurate and true account of what had happened. Arrangements to use CCTV to support safety and quality in the service were not sufficiently robust or established.

Due to the seriousness of the concerns identified during our February 2022 inspection, we used our powers under Section 29 of the Health and Social Care Act 2008 to issue a warning notice to the provider notifying them they failed to comply with Regulation 12, 12 (1), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We gave the service an overall rating of 'Inadequate' and applied Special Measures.

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for Moorlands Neurological Centre on our website at www.cqc.org.uk.

At this inspection we focused only on the issues raised in the warning notice and have assessed if significant improvement has been made.

The hospital is located on a rural site in Cheadle, Staffordshire. The service had up to 8 units and could accommodate up to 39 males and females under 65 years old who had a learning disability or autism. However, when we inspected only 2 units remained in operation and each accommodated just 1 person per unit. Both people were detained under the Mental Health Act 1983. We found 2 units were being renovated to meet the needs of the new service model for patients with an acquired brain injury.

There was a CQC registered manager in post. Moorlands Neurological Centre is registered to provide the following regulated activities:

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

Treatment of disease, disorder or injury.

Summary of this inspection

At this inspection, we visited:

Kingsley - a secure unit for up to four males with autism and complex or challenging behaviours. Accommodation is provided in single occupancy self-contained apartments. There was one person in this unit at the time of our inspection.

Highcroft - a secure unit for up to four males with autism. Accommodation is provided in single occupancy rooms with en-suite facilities. There was one person in this unit at the time of our inspection.

How we carried out this inspection

This was an unannounced focused inspection to see how the provider had improved the service since our previous inspection in February 2022. Our inspection focused on the concerns raised at our previous inspection and the Warning Notice issued following it. We did not look at all of the key questions and so the previous ratings of inadequate remain.

During the inspection we:

observed how staff cared for people in day to day interactions

spoke with 8 staff including nurses, healthcare support workers, ward managers and therapy staff

reviewed 2 care records

reviewed 6 incidents from CCTV and15 incident reports

obtained feedback from external stakeholders

reviewed a range of policies, procedures and other documents relating to the running of the services.

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.

This inspection was carried out by a CQC lead inspector, a support inspector and a specialist advisor.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

The provider must ensure governance process established to identify and review incidents or concerns against closed-circuit television camera (CCTV) footage remain in place to support safety and quality in the service. (Regulation 17)

Summary of this inspection

The provider must ensure staff always accurately report and record incidents that occur in the service. (Regulation 12)

The provider must ensure staff identify and report safeguarding concerns. (Regulation 12)

The provider must monitor the progress of actions or learning identified from the investigation of incidents to ensure they become embedded in the practice of staff to prevent similar incidents occurring again. (Regulation 17)

Action the service SHOULD take to improve:

We told the provider that it should act because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Wards for people with learning disabilities or autism

Safe	Inspected but not rated
Caring	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

Our rating of this service stayed the same. This inspection was focused and we did not have enough evidence to re-rate this key question.

Safety of the unit layout

Areas of the service that remained in use were clean and had been adapted to meet the individual needs of the people who remained in the service. The provider had made environment improvements recommended by our previous inspection. Staff made regular checks of clinic rooms, physical health equipment and resuscitation equipment to ensure it remained in working order.

At the time of our inspection only 2 people remained at the service. Both were accommodated on separate units. They had access to their bedroom, bathroom and to unit areas that were previously communal, including access to fresh air. One unit had been temporarily adapted to provide the person accommodated there with additional space including a secured garden area and sensory room.

Closed-circuit television cameras (CCTV) remained in communal areas of the hospital and externally. The provider displayed signs to inform people of the presence of CCTV. Following feedback from our previous inspection, the provider had taken action to ensure all communal unit areas where incidents occurred were sufficiently covered by CCTV monitoring. The provider had also made access the audio from CCTV recording to be available to support the investigation of incidents or concerns. Appropriate governance arrangements were in place to support the use of audio recordings.

Staff had easy access to alarms and people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

All areas in use were visibly clean. The provider continued to employ dedicated housekeeping staff who worked daily.

Following our previous inspection, we told the provider they should continue to assess and seek solutions to soften and reduce noise on Moneystone unit. As part of the service transformation plan, the provider was in the process of refurbishing the unit previously known as Moneystone to meet the needs of patients with an acquired brain injury. We found the provider had acted on our recommendation and a suitable solution to soften noise on the unit was in place.

Infection prevention and control principles specific to COVID-19 remained in place. Staff had access to sufficient supplies of personal protective equipment (PPE), hand sanitiser and waste bins for the disposal of used items.

Clinic room and equipment

The units remaining in use had small clinic rooms primarily used for the storage and administrations of medications.

Staff had access to physical health monitoring equipment to use with people using the service. This included pulse oximeters and an electrocardiogram. Staff checked, maintained, and cleaned equipment.

Records demonstrated staff regularly monitored and recorded clinic room and fridge temperatures to ensure medications remained safe for use.

Resuscitation equipment was accessible across the site, including oxygen and automated external defibrillators. Staff made regular checks of resuscitation equipment to ensure it remained in working order.

Safe staffing

The service had enough nursing staff who knew the people who used the service and received basic training including training about how to keep people safe from avoidable harm. The service had sufficient nursing staff in post to meet plans for the service transformation.

Following our previous inspection, we told the provider they should continue with actions to ensure sufficient numbers of suitably qualified, skilled and experienced staff were deployed to meet the needs of people who use the service.

Following the provider's announcement in June 2022 to transform the service, occupancy at the service had decreased as alternative placements for people who used the service were found. During this time, managers kept the staffing requirement of the service under review and staffed it flexibly as occupancy changed. At the time of our inspection, the staffing requirement for the service was 2 qualified nurses and 7 support workers during the day, changing to 2 nurses and 6 support workers during the night. During the day, unit staff were supported by multidisciplinary and leadership staff, and during the night a night service manager. The staffing requirement at the time of our inspection allowed unit staff to take regular breaks and there was sufficient staff across the site to respond to emergencies. Our conversations with staff supported this.

The provider had calculated a future staffing establishment to meet the needs of the first patients with an acquired brain injury to be admitted. The provider planned to launch the service with two units, one male and one female, both with 8 beds. The planned staffing establishment of each unit was planned to be 1 qualified nurse and 4 support workers for each shift. This staffing model was different to the one in place to meet the needs of people with a learning disability of autism and reduced the need for temporary staff in the service.

As occupancy in the service reduced from June 2022 onwards, so did the provider's use of temporary staff. In May 2022, agency staff accounted for 23% of total staffing but had reduced to only 5.5% of total staffing in November 2022. Staff told us agency staff were no longer regularly used at the service and those that did work at the service had the necessary skills and experience to do so.

Staff we spoke with identified no concerns about the service being short staffed, instead identifying occasions when the service was over staffed. To engage and retain staff at the service, the provider had introduced a programme of training

and temporary redeployment to locations for patients with an acquired brain injury or people with learning disability or autism. The training programme comprised one week of training specific to neurological presentations, one week management of violence and aggression training specific to neurological conditions and one week 'back to basics' training. The period of staff redeployment was to be for 6 weeks and incorporated time for staff to return to the service for reflection and catch-up.

Following our previous inspection and during the transformation process, the provider continued active recruitment for the service. This included some temporary staff joining the service's substantive staff group. Current substantive numbers of unit based staff more than met the staffing requirement for the initial launch of the acquired brain injury service.

Between April 2022 and November 2022, the service recorded an average staff sickness rate of 4%. This had reduced from 8.3% recorded at our previous inspection. The reduction was in part as a result of reducing COVID-19 sickness amongst staff.

The provider had been successful in retaining staff during the transformation of the service. Between April 2022 and November 2022, the average staff turnover rate was 4.5%. Our previous inspection recorded a staff turnover rate of 4%.

The provider had reviewed the staffing requirement of the multidisciplinary team to meet the needs of patients with an acquired brain injury. Where roles were vacant or newly created, active recruitment was in place. New additions to the service's multidisciplinary team included a dietician and neurological psychologist. One of the service's existing consultant psychiatrist was to remain in post with peer support form a local neurological psychiatrist in place.

Mandatory training

The provider ensured mandatory training was available to all staff. The provider's completion target for mandatory training was 85%. At the time of our inspection, the provider reported an overall staff completion rate of 93%. Courses included as part of mandatory training appeared appropriate and included those aimed at keeping people who used the service safe.

One mandatory course, Epilepsy Awareness, recorded a staff completion rate of only 66%. However, the course had been recently introduced and the provider was monitoring staff completion.

Managers monitored mandatory training and alerted staff by email and letter when they needed to update their training. The provider planned a programme of 'back to basics' training for all staff as part of the service transformation programme and would include elements of the mandatory training courses. This included safeguarding, incident recording and the culture of care.

Assessing and managing risk to people and staff

Use of restrictive interventions

Monitoring of incidents and CCTV footage introduced following our previous inspections continued to identify incidents where staff did not always follow plans or use approved physical interventions when managing incidents or behaviour that challenged with people who used the service. However, staff worked together to understand and implement plans to support people who used the service.

Inspected but not rated

Wards for people with learning disabilities or autism

The provider continued to experience challenges to ensure staff always used recognised interventions and techniques to manage incidents and behaviour that challenged with people in their care. Following our previous inspection, we told the provider they must demonstrate improvement in this area. The provider submitted an improvement plan to meet this requirement. The plan identified ward based learning sessions for staff, random CCTV reviews alongside footage of specific incidents, and weekly analysis of incidents.

Between April 2022 and November 2022, the provider recorded 15 incidents that identified a staff practice or conduct concern. Of these, 9 raised concern about staff member's use of recognised interventions and techniques to manage incidents and behaviour that challenged with people in their care. The incidents identified concerns for 17 substantive staff and 10 temporary staff. The provider took appropriate action to the identified concerns. We saw investigations with outcomes including escalation to external services, staff dismissal, and Disclosure and Barring Service referrals. Where staff remained in the service, there was additional support through training, competency checks and supervision.

The provider required staff working directly with people who used the service to complete management of violence and aggression (MVA) training. The training included de-escalation and conflict resolution to promote the use of physical interventions as a last resort. At the time of our inspection, the provider recorded a completion rate of 86%, this was lower than the 89% completion rate reported at our previous inspection. Prior to working shifts, the provider ensured agency staff had MVA training that aligned with their own.

We found plans in place to guide staff in recognised interventions and techniques to manage incidents and behaviour that challenged with people in their care. Staff from all disciplines collaborated to develop plans that were personalised to the individual needs of people who used the service. Plans were developed and updated as people's risks or needs changed. Staff shared information about interventions and techniques to use with people during handovers, multidisciplinary meetings and in learning from incidents. We saw evidence of the interventions and techniques used by staff were having a positive contribution to reduce incidents of behaviour that challenged.

Staff told us risk management plans, care plans and positive behavioural support (PBS) plans were available to support their practice with people who used the service. Staff accessed these records electronically or from easily accessible folders on units. Staff told us they had opportunity at the start of shifts to brief themselves on the best way to engage and work with people who used the service.

The provider supported unit based staff to understand and implement plans with people who used the service. The service had an identified positive and safe practice lead. The lead attended weekly to contribute to incident analysis meetings, review CCTV footage, and support staff based on wards. A staff member trained to deliver MVA training had also been deployed to support unit based staff and psychology staff supported units to implement PBS plans. During this inspection we saw staff working together to better support an emerging behaviour that challenged from a person who used the service. However, findings from the reviews of CCTV saw that this was not always effective in ensuring staff understood and implemented plans.

Safeguarding

Monitoring of incidents and CCTV footage introduced following our previous inspections continued to identify incidents where staff had not always identified and escalated abuse or improper treatment of people who used the service. However, there was improvement in the number of staff speaking up with concerns related to safeguarding or culture in the service. We continued to see the provider took immediate and appropriate action to the concerns identified or raised to them

Inspected but not rated

Wards for people with learning disabilities or autism

The provider continued to experience challenges to ensure staff always understand their individual responsibilities to prevent, identify and report abuse or ill treatment of people in their care. Following our previous inspection, we told the provider they must demonstrate improvement in this area. The provider submitted an improvement plan to meet this requirement. Identified actions from the plan included additional closed culture training, closed culture resource packs and out of hours spot checks from the senior leadership team.

Between April 2022 and November 2022, the provider recorded 23 episodes of staff speaking up with concerns related to safeguarding or culture in the service. In the same period, the provider recorded 3 incidents where it was identified staff present, but not directly involved in the incident, failed to identify or report a safeguarding concern arising from a colleague's treatment of a person who used the service. The incidents identified concerns for 5 substantive staff and 4 temporary staff. The provider identified the concerns and took appropriate action. We saw investigations with outcomes including escalation to external services, staff dismissal, and Disclosure and Barring Service referrals. Where staff remained in the service, there was additional support through training, competency checks and supervision.

The provider required staff working in the service to complete adult and child safeguarding training. Staff competed safeguarding training appropriate to their role in the service. When we inspected, the service recorded an overall staff completion rate of 95%. Safeguarding training specific to registered healthcare staff in the service recorded a 100% completion rate. The provider had an identified safeguarding lead in the service.

At the time of our inspection, the provider reported an overall staff completion rate of 91% specifically for closed culture training. The training was delivered face to face over 1 day and allowed opportunity for staff to discuss scenarios and participate in reflective practice. The programme of 'back to basics' training for all staff included further closed culture training.

Staff we spoke with demonstrated a good understanding of their individual responsibilities to prevent, identify and report abuse or ill treatment of people in their care. They felt the provider supported their safeguarding practice through training and availability of the service's safeguarding lead.

The hospital manager facilitated a weekly meeting with people who used the service during which they were asked specifically if they felt safe in the service.

The hospital manager identified high levels of activity in the service to review incidents and monitoring CCTV following our previous inspection. They also reported an increase in staff speaking up and raising concerns about their own practice and the practice of colleagues with people who used the service. The hospital manager believed staff rarely acted maliciously with people who used the service, instead reviews most often identified developmental opportunities or the need for additional staff support. We saw this illustrated in an incident we reviewed during the inspection when a staff member responded inappropriately during an incident of behaviour that challenged. Other staff present acted immediately to correct the staff member and the provider offered support through additional training and supervision.

Track record on safety

Processes to review incidents that occurred in the service had improved and were sufficient to identify and investigate concerns about safety and quality in the service. However, the provider remained challenged to ensure staff always accurately reported and recorded incidents that occurred in the service. It was not clear staff always used lessons learned following incidents to prevent similar incidents occurring again.

Inspected but not rated

Wards for people with learning disabilities or autism

The provider continued to experience challenges to ensure staff always accurately reported and recorded incidents that occurred in the service. This was a concern identified at our previous inspection. In response to this concern the provider made refresher training and coaching on reporting and recording incidents available to staff, although this was not part of mandatory training requirements. Multidisciplinary staff and managers met daily at morning meetings. The meeting included review and sign-off of all incidents reported in the service the previous day. Incidents reports with insufficient details or missing essential information were returned to ward staff for completion.

During this inspection, we reviewed 6 incident reports from November 2022 against the corresponding CCTV footage which continued to demonstrate shortfalls in staff member's accuracy and detail when recording incidents. We identified concerns in 3 incidents reviewed. In one example, when compared to CCTV footage the incident report failed to identify the correct number of staff involved in the incident or detail roles individual staff took in applying physical interventions. However, the CCTV footage made it apparent the staff member reporting and recording the incident did not have a clear view of the actions of others involved. Managers identified some staff continued to experience challenge to always accurately record incident and planned further training for staff as part of the planned 'back to basics' programme.

Between April 2022 and November 2022, the provider recorded 2,780 incidents in the service (compared to 3,026 in the same time period of 8 months at the most recent inspection). Of those, 2,220 were recorded as incidents of violence and aggression. The outcome of Level 1-No Harm was recorded for 1,305 incidents and Level 2-Low Harm for 813 incidents. For example, a Level 2-Low Harm incident might require staff to provide some first aid to the person involved.

In the same period, the provider identified 13 serious incidents. Incidents of violence and aggression accounted for 8 of those. From September 2022 onwards, no serious incidents had been recorded in the service.

Our previous inspection identified arrangements to review incidents against CCTV footage had not been sufficiently robust to protect all people who used the service. We saw the immediate changes made by the provider following our previous inspection continued to be implemented in the service. This included daily CCTV review of all incidents recorded in the service with an outcome of Level 3-Moderate Harm or above, daily CCTV review of at least two randomly incidents recorded with an outcome of Level 1-No Harm or Level 2-Low Harm, and daily CCTV review of all incidents recorded for people identified as particularly vulnerable or a high level of need. At the time of our re-inspection, staff reviewed all incidents recorded for both people remaining in the service.

Staff knew what incidents to report and how to report them. The provider maintained a record of all CCTV footage reviewed, including as part of live reviews or as part of an incident review. The record detailed any documents checked against the CCTV footage, the outcome of the review and any resulting actions. Between April 2022 and November 2022, senior staff within the service reviewed 774 pieces of CCTV footage of which 45 identified further investigation or action. In the same period, an additional 973 pieces of CCTV footage specific to incidents were reviewed by senior staff external to the service, of which 26 identified further investigation or action. In addition to identifying practice or conduct concerns by staff, other areas of concern included incident reports failing to be a true account of the incident seen, incorrect use of personal protective equipment and environmental concerns.

Managers investigated incidents in the service. We saw examples of investigations as a result of staff raising concerns in the service and following review of live or recorded CCTV footage. Managers made use of a wide range of resources to investigate incidents. For example, staff interviews, CCTV footage, clinical records, training records. Investigation reports were detailed and where actions were identified they were accompanied by up to date action plans.

Inspected but not rated

Wards for people with learning disabilities or autism

The provider shared feedback and learning from the investigations of incidents with staff. This occurred through email communications, weekly calls with the hospital managers, supervisory practices and debriefs. Email communications were entitled 'Golden Threads' and shared with all staff in the service. We reviewed a selection of communications circulated between April 2022 and November 2022. They clearly and concisely identified the incident and shared actions staff should take if a similar incident occurred. However, despite this it was not clear actions or learning following incident investigations always embedded in the practice of staff to prevent similar incidents occurring again. For example, in May 2022 there was a serious of incidents where staff failed to always safely manage harmful objects that could be swallowed.

Is the service caring?

Inspected but not rated

Our rating of this service stayed the same. This inspection was focused and we did not have enough evidence to re-rate this key question.

The provider's monitoring of incidents and CCTV footage continued to identify concerns that some staff did not always treat people using the service with compassion and kindness. However, our inspection observed staff working well with people who remained at the service and recent feedback about staff's support to people transitioning to new services was positive.

The provider's increased monitoring of incidents and CCTV footage continued to identify concerns that some staff did not always treat people using the service with compassion and kindness. This included some staff not following plans to manage behaviour that challenged, inappropriate use of force to manage behaviour that challenged, and staff who failed to identify or report a safeguarding concern arising from a colleague's treatment of a person who used the service. However, managers also used monitoring activities to identify and record positive interactions between staff and people who used the service. For example, staff member's use of recognised de-escalation interventions to prevent or manage an incident of behaviour that challenged.

During this inspection, our observations of staff conduct and behaviour with people using the service was more positive. We saw interactions delivered with care and with clear and accessible language for people who used the service. Staff supported people to make choices about food, drink and activities. Staff used 'now and next' interventions with people to guide behaviour and manage behaviour that challenged. Staff supported people using the service to prepare and transition to future placements.

When we previously inspected there were 23 people residing at the service. At this inspection, only 2 people remained. Both had alternative placements identified and transition plans in place for early 2023. We saw 4 people from the service had transitioned to community placements, while others went to locked or low secure facilities. Feedback from two placing commissioners identified staff had gone above and beyond in care, support and reassurance to ensure their people were prepared and supported to transition to a new service. Another placing commissioner thanked staff for the care provided and the positive progression their person had made during admission to the service.

Is the service well-led?

Inspected but not rated

Wards for people with learning disabilities or autism

Inspected but not rated

Our rating of this service stayed the same. This inspection was focused and we did not have enough evidence to re-rate this key question.

Leadership

The experience of leaders by staff in the service continued to be positive. Plans to transform the service had been communicated well, staff felt well informed and supported during the process.

The experience of staff of the local senior leadership team continued to be positive. Staff told us they were visible approachable and easy to speak with. Staff also provided examples of regional and directorate leaders visiting and supporting the service.

Following our previous inspection, the leadership team developed and implemented a more robust plan of out-of-hours visits to the service. Out of hours visits supported managers visibility and accessibility in the service. They also provided an opportunity to engage staff and observe practice and conduct.

Vision and strategy

The provider had implemented service transformation plans that meant people with a learning disability or autism would no longer be supported at the service. Feedback from commissioners on the implementation of the plan was positive.

Staff told us leaders had communicated plans about the service transformation well. They felt it had been thoroughly explained and appeared well planned. Leaders communicated through team meetings, question and answer sessions and weekly communications emails. Staff told us actions of the leadership team provided reassurance about the service transformation.

To engage and retain staff at the service, the provider had introduced a programme of training and temporary redeployment to locations for patients with an acquired brain injury or people with learning disability or autism. The training programme comprised one week of training specific to neurological presentations, one week management of violence and aggression training specific to neurological conditions and one week 'back to basics' training. The period of staff redeployment was to be for 6 weeks and incorporated time for staff to return to the service for reflection and catch-up.

Leaders had calculated the staffing model for the new service type and communicated the planned establishment of each unit to meet the needs of those using the service.

Culture

Staff continued to feel respected, supported and valued. The provider had taken action to support speaking up in the service and staff felt confident to do so. Managers recognised risks to closed culture remained in the service and planned actions to manage this.

Inspected but not rated

Wards for people with learning disabilities or autism

Staff we spoke with felt respected, supported and valued for the work they did. This was consistent with findings from our previous inspection. Staff felt motivated about the service transformation and supported by the provider through training and shadowing opportunities. The hospital manager thanked staff for the work they did as part of their weekly email communication, this also identified and shared good practice that had occurred in the service.

Following our previous inspection, the provider had taken actions to support raising concerns and speaking up at the service. This included site visits by the provider's Freedom to Speak Up Guardian and Director of Culture, additional training, and awareness days specific to culture and speaking up. Staff we spoke were familiar with processes in place to raise concerns within the service or to an external agency.

Staff felt confident to raise concerns and felt able to do so without fear of retribution. One staff member told us that when raising a concern to managers, they'd felt listened to and their concern had been acted upon.

Managers identified that changing the service model would not eliminate the risks to a closed culture. They identified and understood indicators that remained, including location, staff relationships and patient vulnerability, and the need to continue to monitor and engage staff to manage the risks of a closed culture developing. A training programme had been implements with the new service in mind and enabled a 'back to basics' training for all staff, to include safeguarding, incident recording and culture of care.

Governance

Following our previous inspection, the provider had commenced their service transformation with plans implemented to no longer accommodate people with a learning disability or autism.

The provider worked closely with stakeholders and people who used the service to successfully identify and support transition to alternative placements. We saw demonstrated improvements in some governance processes to have better oversight of safety and quality in the service.

The processes in place continued to identify some concerns about the practice and conduct of some staff and the provider was able to take appropriate action. However, this demonstrated that the actions taken by the provider had not been fully effective in eliminated poor and unsafe practices from staff to people accessing the service.

Following our previous inspection, we told provider they must ensure governance systems are robust and work effectively to ensure safety and quality in the service. We saw the provider had made improvements, particularly in the use of closed-circuit television camera (CCTV) footage to monitor the service and to investigate concerns or incidents. This monitoring continued to identify staff who did not always following individual plans or always use approved interventions with people who used the service. The provider monitored all reported incidents for people particularly vulnerable or with a high level of need. However, it is recognised that this oversight has not prevented the recurrence of poor and unsafe practices.

Actions to support staff to identify concern related to safeguarding or culture in the service had supported more staff to speak up. These activities appeared more robust to support safety and quality in the service but also continued to identify concerns about the practice and conduct of some staff with people who used the used. However, there continued to be some incidents where staff did not always identify, and report concerns about the conduct or practice of colleagues.

Inspected but not rated

Wards for people with learning disabilities or autism

Since our most recent inspection, we noted significant improvements the provider had made to monitor the safe delivery of care to people in the service. The provider now clearly monitored and reviewed significant numbers of interactions between staff and people in the service and the provider was now able identify occasions when staff behaviour did not reflect the values of the provider. This level of monitoring enabled the provider to take swift action to investigate and take action where necessary. Managers provided assurance that the systems in place would continue to monitor the delivery of safe care in the new service for patients with an acquired brain injury.

Reviews of incidents against corresponding CCTV footage identified continued challenge ensure staff always accurately reported and recorded incidents that occurred in the service. Managers recognised this and planned further training for staff as part of the planned 'back to basics' programme. However, during our review we noted CCTV footage provided additional oversight and detail of staff actions during incidents that would often be difficult for staff directly involved in to note or record. Although often clearly and concisely identified and communicated following incidents, it was not clear actions or learning always embedded in the practice of staff to prevent similar incidents occurring again.

The provider demonstrated improvement to address other concerns identified at our previous inspection. This included actions to ensure sufficient numbers of suitably qualified, skilled and experienced staff were deployed to meet the needs of people who used the service. The provider also demonstrated how weight monitoring and local health initiatives would support people who used the service to remain healthy. We saw that one person who remained in the service had a healthy eating plan in place and this demonstrated some reduction in weight. The provider had established additional monitoring activities and health initiatives that would remain in place during the service transformation. This included a dietician at the service, regular reviews of hospital menus for healthier options, portion control plates and timetables of community activities.

Engagement

In June 2022 following discussions with people using the service, family members, staff and the Integrated Care Board (ICB), the provider announced to CQC that people with a learning disability or autism would no longer be accommodated at the service. The provider saw this as an opportunity to better align with the principles of the Transforming Care Agenda (2017) and for people accommodated at the service to be supported in services closer to their home areas. The provider had not decided on a new service model but was clear about plans to retain and retrain existing staff. In September 2022, the provider shared a new service model for patients with an acquired brain injury. The provider planned 'Phase 1' of the service to open with 16 beds across two wards with admissions managed to support staff practice and conduct with the new patient group.

Following our previous inspection, the provider worked closely with commissioners to identify and place people accommodated in the service with a suitable alternative. From June 2022 following announcement of the service transformation, this included additional weekly meetings to discuss the needs and discharge plans of individuals. The host commissioner initially planned for an end to end process of 12 weeks. However, the provider worked flexibly with placing commissioners and people remained in the service until a suitable alternative was identified and a safe transition facilitated. The host commissioner met regularly with the provider, reporting them to be honest and open at all times. They also noted the providers increased activities to monitor CCTV footage in the service and a reduction in incidents in line with the discharge of people from the service.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure governance process established to identify and review incidents or concerns against closed-circuit television camera (CCTV) footage remain in place to support safety and quality in the service. The provider must monitor the progress of actions or learning identified from the investigation of incidents to ensure they become embedded in the practice of staff to prevent similar incidents occurring again.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure staff always accurately report and record incidents that occur in the service. The provider must ensure staff identify and report safeguarding concerns.