Cygnet Clifton Limited

Cygnet Alders Clinic

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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced, focused inspection of Cygnet Alders Clinic due to concerns about some areas of service quality. We did not tell the provider we were coming before our inspection and only looked at two of our key questions; how safe and how well-led is the service?

Following this inspection our rating of good and well-led went down. We rated them as requires improvement because:

- The high turnover of leaders had affected the day to day running of the service. There had not been a stable leadership team in place for some time. This led to gaps in leadership capacity and oversight at service level that had impacted the safety of patients and staff. For example, staff had not received consistent, regular supervision.
- Incidents relating to patient safety were not always reported, recorded and investigated.
- Record keeping systems were not easy for staff to navigate and information was stored in multiple different places. This meant staff did not have easy access to information relating to patients' care and treatment. On occasion this had meant decisions relating to individual patient's care had not been communicated during handover.
- The service had not maintained clear communication with external stakeholders. This meant agencies involved with the safeguarding and coordination of patients, for example care coordinators, were not always informed of potential risks or changes to patient care.

However:

- Wards were safe and clean. There were enough nurses and doctors who had completed basic training to keep patients safe. Staff completed individual risk assessments for each patient and kept these up-to-date. Staff minimised the use of restrictive practices. Medicines were administered, prescribed and reviewed in line with national best practice.
- The service worked to a recognised model of mental health rehabilitation.
- The interim management team had started to make improvements. Staff said that culture within the service had improved and within the last six months they had received more support in their day to day role.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	We found areas of improvement relating to the leadership, governance and safety of the service.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Alders Clinic

Cygnet Alders Clinic is a rehabilitation service in Gloucestershire. The 20-bedded unit provides specialist support for women with a personality disorder. Many patients have additional comorbidities and have experienced complex trauma.

At the time of this inspection there were 12 patients using the service. The provider had paused new admissions to the service to concentrate on service quality and prioritise the establishment of a new management team.

There are three wards; Severn, Avon and Coln. Each ward provides treatment around the different stages of a patient's recovery journey. Patients are admitted onto Severn ward, which has eight beds, for assessment and focus on managing their more acute mental health needs. Once ready, patients move onto Avon ward and then Coln ward, both of which have six beds. Here, patients focus on rebuilding their independent living skills through psychological and occupational therapies to prepare them for discharge.

Patients from across the country are admitted to the service.

We last inspected Cygnet Alders Clinic in January 2019. We inspected the whole service and looked at all five of our key questions. We found the service was 'Good' overall and rated it as 'Outstanding' for caring.

Since our last inspection there had been many changes within the service including those caused by the COVID-19 pandemic. There had been multiple changes to the management team at Cygnet Alders. There had also been an increased turnover of staff.

In the six months prior to our inspection concerns had been raised to us by members of the public and other stakeholders about staffing levels, medication management and leadership of the service. Because of this we decided to carry out an unannounced, focused inspection.

At the time of this inspection there was no registered manager in post. The last Hospital Director (who was also the Registered Manager) was in post from November 2021 to May 2022.

What people who use the service say

During this inspection we spoke to two patients and four carers or family members of patients who used the service. We also reviewed feedback recently collected from patients.

We received mixed feedback about the service. Patients said they felt safe but there had been times in the last six months where the wards had felt unsettled. They said the service had recently improved and felt calmer. They said the interim managers were visible.

However, they felt that due to the turnover of staff and regular use of agency staff they did not get regular one-to-one time with a nurse who knew them well. Carers also commented on the 'newness' of staff and that some were not as experienced as others. Some said they were not comfortable with the number of male staff members within the service and thought there should be more activities provided.

Summary of this inspection

Some families and carers were not aware of the recent management changes, this included carers who were more involved with patients' care and treatment.

We received similar feedback during a Mental Health Act visit in March 2022.

How we carried out this inspection

As this was a focused inspection, we only looked at specific areas of safety and leadership.

The inspection team:

Visited the location and made checks on the environment

Observed how people were being cared for and joined a handover meeting

Spoke with twelve members of staff including the interim Clinical Lead for the service, Ward Manager, nursing staff and other members of the leadership team

Spoke with two patients and four carers or family members of patients

Reviewed records relating to nine patients' care and treatment

Looked at a range of policies, procedures and other documents relating to the running of the service

Spoke to external stakeholders to gain feedback on the overall quality of the service.

Two CQC inspectors and a Specialist Advisor with a background in inpatient and acute mental health services visited the service on 7 June 2022. Following our visit an Expert by Experience (someone with lived experience of using mental health services) conducted virtual interviews with patients. We also conducted virtual interviews with staff and other stakeholders. We completed our final remote interview on 17 June 2022.

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.

Areas for improvement

Action the service 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 there is a consistent and effective management team in place. This team must ensure robust governance processes are implemented on site and provide appropriate support and leadership to staff; this includes the completion of regular supervisions.

Summary of this inspection

- The provider must ensure that record keeping systems enable staff to maintain an accurate, complete and contemporaneous record in respect of each patient's care. These records must be accessible to staff to ensure they can access and share information in a timely way. This includes records kept in relation to the patient's medication and risk profile.
- The provider must ensure all incidents, including safeguarding concerns are reported, investigated and any learning is embedded to mitigate potential future risks. The provider must also ensure that the relevant notifications are made to external bodies in a timely way.

Action the service SHOULD take to improve:

- The service should ensure medication cupboards are locked where necessary.
- The service should ensure procedures for informal patients taking leave or leaving the ward support general health and safety requirements, particularly those related to fire evacuation policies.
- The provider should improve service quality before accepting new admissions to ensure patients receive safe care and treatment. The provider should also ensure quality improvement activity is resumed as soon as possible.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	☆ Outstanding	Good	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement;

Safe and clean care environments

All wards were clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and updated risk assessments of all wards areas and removed or reduced any risks they identified.

Staff had taken steps to mitigate potential blind spots on the wards. This included the installation of convex mirrors. CCTV was in place; footage was only used to aid the investigation of specific incidents.

Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. Staff completed ligature risk assessments for each ward. Updates to some anti-ligature fittings had been scheduled for August 2022 but many were already in place.

Staff had access to alarms and patients had access to nurse call systems. Alarms were tested on a regular basis.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date.

Staff followed the infection control policy, including handwashing. The team completed quarterly infection control audits to identify areas of non-compliance or improvement needed.

Clear protocols were in place to prevent the spread of COVID-19.

Clinic room and equipment

Clinic rooms were fully equipped. Staff had access to resuscitation equipment and emergency drugs. Staff checked this equipment on a regular basis but there had been some occasions where daily checks had not been recorded.

We found that although the main clinic room doors were locked, some internal cupboards that contained medicines were not locked. In March 2022 a patient had been able to gain entry to the clinic room and remove some medicines. Following this the provider had identified that all cupboards containing medicines should be locked when not in use.

Staff checked, maintained, and cleaned equipment. There was a separate 'treatment' room located off the ward available for physical health monitoring checks for example electrocardiogram (ECG) monitoring and blood tests.

Safe staffing

The service had faced challenges with staff turnover, recruitment and retention. On the day of our inspection there were enough nursing and medical staff relative to the reduced number of patients. These staff had received training to keep people safe from avoidable harm.

Nursing staff

The service had faced significant challenges in relation to staff retention and turnover.

Despite the provider's recruitment campaign there were still vacancies. There were four nursing staff vacancies and 14 support worker vacancies. The provider had successfully recruited to all four nursing vacancies and 11 of the support worker vacancies. However, these members of staff had not started at the time of our inspection.

At the time of our inspection the turnover rate for staff was ten per cent. During our inspection two members of senior staff also announced their departure from the service.

Additional staffing requirements and vacancies were filled by bank and agency staff. This sometimes impacted on patients' experience. For example, patients did not always have regular one-to-one sessions with a member of nursing staff they were familiar with. Some patients and carers told us this had made it difficult to build meaningful relationships with staff.

Patients and staff also raised concerns that the gender mix of staff on duty meant that male staff were sometimes required to cover one-to-one observations with female clients. Some patients, carers and staff felt this was not always appropriate. The provider was aware of this feedback and took steps to avoid this where possible.

Leaders were aware of these issues and had taken steps to address the staffing challenges and minimise impact on patient safety and experience where possible. Managers worked hard to limit the use of bank and agency staff and requested staff familiar with the service. In May 2022, 30 per cent of shifts had been filled by agency staff, a reduction from the previous month. Bank and agency staff had received an induction and understood the service.

On the day of our inspection the service had enough nursing and support staff to keep patients safe. The service had temporarily closed to new admissions and had 12 patients at the service. Managers made this decision to allow time to make improvements and onboard new staff. Senior managers told us the service would not resume admissions until newly recruited staff had been fully inducted to the service.

Staffing levels were adjusted according to the needs of the patients and there had been no shifts were there had been gaps in staffing numbers. Patients rarely had their escorted leave cancelled even when the service was short staffed.

Medical staff

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had enough daytime and night time medical cover, seven days a week. The service had a longstanding, experienced consultant psychiatrist in post. The consultant was also supported by a speciality doctor.

A doctor was available to go to the ward in an emergency. Staff also knew when to call for emergency assistance using the local ambulance service.

Mandatory training

Most staff had completed and kept up-to-date with their mandatory training. Across the service 78 per cent of staff had completed their mandatory training. If the completion of mandatory training modules did not meet the providers internal targets managers were aware of this and had plans in place to ensure this training was completed as soon as possible.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission to the service using a standardised tool, and reviewed this regularly, including after any incident. We reviewed nine patient's folders and found staff had completed a 'START' risk assessment for each patient that was detailed and up-to-date.

The provider had developed its own risk assessment tool which staff used to review each patients' risks daily. Staff assessed risk to each patient and discussed any changes during handovers and multidisciplinary morning meetings.

Management of patient risk

Staff knew about risks to each patient but there had been occasions where they had failed to prevent or reduce these risks. For example, one patient had gained unsupervised access to a kitchen knife. This had not resulted in any serious harm to the patient or staff members but should not have happened.

Staff had not always shared key information to keep patients safe. We found one incident where information had not been communicated at handover between shifts which had meant a patient had been given access to medication outside of their care plan. Staff were aware of these issues and had made changes to improve. For example, the team handover sheets had been reformatted to highlight key risks during handovers and additional weekly care planning reviews had been introduced for staff.

Staff followed procedures to minimise risks where they could not easily observe patients. Patients were individually assessed to see if they required enhanced observation from staff to help keep them safe.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The provider had plans to upskill new members of staff in specific areas to enhance their abilities to manage and respond to specific risks common to people with personality disorders. This included wound care management and introduction to psychological therapies and approaches.

Use of restrictive interventions

Staff anticipated, de-escalated and managed challenging behaviour well. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Levels of restrictive interventions were generally low.

Staff participated in the provider's restrictive interventions reduction programme.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

Staff followed NICE guidance when using rapid tranquilisation.

The service did not use long term segregation or seclusion. Despite the challenges with staffing the service had enough staff on each shift to carry out any physical interventions safely.

Where restrictions were in place the provider had made attempts to mitigate the impact on patients. For example, cigarette lighters were not allowed on site due to the potential risk to patients. Instead, there were designated smoking areas within the garden on each ward.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the service had not always worked well with other agencies to do so.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm.

There were clear procedures to keep children visiting the service safe. A separate visiting room was available off the main wards and the team worked with families to arrange visits in the community where possible.

The interim clinical manager was the safeguarding lead for the service.

However, there had sometimes been delays in raising safeguarding referrals with external bodies. We found three incidents where staff had failed to submit safeguarding referrals to the Local Authority in a timely way. We also received feedback from external agencies including patients' care coordinators and commissioners that they had not always been informed about individual safeguarding concerns or changes to patient's risk management plans. The interim management team recognised this and had plans in place to improve this.

Staff access to essential information

Staff did not always have easy access to clinical information.

Information relating to patient care and treatment was stored across multiple electronic record keeping systems. This sometimes made it difficult for staff to find information relating to patients care and treatment.

This issue had been raised at a number of other locations managed by the provider. Senior managers were aware this was a wider area for improvement.

We also found some examples where information about patient's care and treatment had not been recorded accurately. For example, there had been one incident where the administration of medicine had not been clearly recorded.

However, patient notes were stored securely.

Medicines management

The service used systems and processes to safely prescribe and administer medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health. However, we found some areas for improvement in relation to record keeping and storage of medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the medicines administration records for nine patients and found medicines had been administered in line with individual care plans.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Safety alerts around medication were shared with staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

However, staff did not store all medicines in line with local procedures. During our inspection we found that in the clinic rooms on Coln and Severn ward there were cupboards and fridges containing medicines that had been left unlocked. The controlled drugs cabinet was secure and regular stock takes had been completed.

Staff did not always complete records about patients' medicines accurately. In one patient's notes, staff recorded a medicine had been prescribed for a 'dry cough'. On review, this medicine had not been prescribed or administered and it was unclear why this had been included in the patients notes.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Records relating to the use of high dose antipsychotic therapies (HDATs) were not always kept up-to-date or stored in a place that was accessible to clinical staff. On the day of our inspection staff could not locate specific HDAT care plans for two patients. Following our inspection, the provider was able to evidence that these medicines had been reviewed and that this had been a recording issue.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report but did not always record incidents clearly in line with policy. This meant incidents were not being reviewed or investigated by managers in a timely way and lessons learnt were not being identified.

We found one recent incident where a patient had made allegations of verbal abuse by a former staff member that had not been recorded by staff or investigated, despite previous managers being made aware of the incident.

Staff commented that multiple systems used to record information sometimes made it difficult to see what action had been taken following an incident, including safeguarding referrals.

Learning from incidents was not always implemented. Following an incident involving a patient's medication the provider had identified learning, but we found this had not yet been embedded. For example, managers told us weekly medication review meetings had been introduced to provide additional support and training to less experienced staff in medication management practices. However, staff we spoke to on the day of our inspection were not aware of these sessions and had not yet attended them.

In addition, it had also been highlighted that medication cabinets within the clinic rooms should be locked when not in use. On the day of our inspection we found some medication cupboards were not locked.

However, where incidents had been reported and investigated, we found that managers had debriefed and supported staff after any serious incidents. Staff met to discuss the feedback and look at improvements to patient care. Staff could provide examples of lessons learnt following incidents and there was evidence that changes had been made as a result.

Managers were aware that reporting, recording and learning from incidents was an area for improvement and had started to improve this process. This included the introduction of lesson learnt folders in staff offices.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement;

Leadership

There had been a relatively high, unplanned turnover of managers within the service which had led to gaps in leadership capacity and experience.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

In the 12 months prior to our inspection there had been multiple changes to the management team at service level. There had been no ward manager in post between November 2021 and May 2022. At the time of our inspection there was no Hospital Director or Clinical Lead in post. During our inspection there were further changes to the senior staff team including the departure of the Regional Operations Director who had been acting as the interim Hospital Director.

The turnover in leaders and experienced nursing staff members had impacted the support available to ward teams. For example, at the time of our inspection only 54 per cent of staff had received clinical supervision.

Patients and staff also commented that the multiple changes in leadership had felt unsettling and had added to anxieties caused by the COVID-19 pandemic.

The provider had made clear attempts to fill vacant leadership posts. The provider had also arranged interim support for the service by moving managers and leaders from other nearby services to help run the site. A new Hospital Director and Clinical Lead had been appointed and were due to start shortly after our inspection. There was one ward manager in post, and another had been recruited.

Staff that had been encouraged to pursue leadership development opportunities at ward level required more time to establish their management skills and gain experience. Some commented that due to the changes in managers, there had not always been a consistent experienced member of staff in place to support their development.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff understood and worked towards the provider's vision and values.

The previous Hospital Director had worked with staff and patients to re-embed a clear recovery care pathway at ward-level, that matched the provider's overall vision for the service.

Staff and patients had the opportunity to contribute to discussions about changes within the service.

Culture

Staff at ward level felt respected and valued. They said the culture had improved in the last six months. Staff had opportunities for career progression. Staff could raise concerns without fear.

Despite the various changes to leaders and managers, staff felt respected and valued at ward level. The provider had held various events and staff appreciation days to thank staff. Staff had also received a pay increase.

Staff worked well together and where there were difficulties managers dealt with them appropriately.

Relationships between different teams had improved. Prior to November 2021 there had been concerns about the interpersonal relationships between staff. Senior leaders within the region had organised an independent review and had put an action plan in place to address any underlying issues. Current staff felt these had now been resolved and we found no evidence where these relationships had impacted patient care directly.

Staff appraisals included conversations about career development and how it could be supported. At the time of our inspection 88 per cent of staff had received an appraisal.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Where staff had been recruited internationally, the provider had given them extra support to integrate into the service and living in a new country.

Staff had access to support for their own physical and emotional health needs through an Occupational Health service. The service had also implemented reflective practice sessions for staff to attend. These sessions were an open forum for staff facilitated by the psychology department. Staff mindfulness sessions were also offered.

Managers dealt with poor staff performance when needed. Staff commented that in the last six months managers had intervened fairly to address individual staff performance.

Levels of staff sickness were reducing. In January 2022 the rate of staff sickness was ten per cent; at the time of our inspection staff sickness was two per cent.

Staff felt able to raise concerns without fear of retribution. However, staff did not always know about the providers Speak Up Guardian and some were not aware of when they had last visited the service. The provider had noted this as an area for improvement.

Governance

We found some governance processes did not always operate effectively at team level.

The multiple changes to the leadership team within the 12 months prior to our inspection had impacted the daily running of the service. For example, there had been delays in the reporting and reviewing of incidents. We also found examples where learning from incidents had not always embedded.

Changes to local procedures were not always implemented smoothly. New procedures for informal patients leaving wards to take community leave had led to one incident where a patient had left the service without staff being aware. Staff were concerned about this and felt it could impact the safety of patients, if there was a fire on site and staff were not aware if a patient had left or not. Staff had raised their concerns with interim managers but were unsure what action had been taken.

Although the provider had robust governance processes in place these had not always been implemented on site. For example, we found gaps in records relating to daily checks completed on resuscitation equipment. Some clinical audits had not been completed for some time including those relating to blanket restrictions. This meant the provider did not have full oversight of potential issues within the service.

The provider was aware of some of these issues and had an action plan in place to improve local governance processes.

Management of risk, issues and performance

Changes to the leadership team had impacted on the management of risks, issues and performance.

The turnover of managers had affected service delivery. Interim leaders had prioritised the management of immediate issues, such as recruitment, and had not had time to focus on improvements in other areas of service. For example, processes to support learning from incidents had not been implemented in line with the provider's own policies and procedures. The completion of wider quality improvement work had also been paused to allow staff to focus on managing the immediate day-to-day delivery of care.

However, the interim team were focusing on re-embedding processes to better manage service performance and drive improvement. The interim management team had worked with the provider's internal quality team to complete a thorough review of overall service quality. There was an action plan in place to address areas for improvement. The interim management team had worked hard to implement most of these changes, but further time was needed to fully embed them and ensure they were sustainable.

The service had also used a report following a Care Quality Commission Mental Health Act (MHA) monitoring visit to make improvements to the service.

The service had a risk register in place. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.

Managers from other sites met on a weekly basis to discuss performance across the region. The interim management team had been attending these calls.

The service had contingency plans in place for emergencies. For example, adverse weather or a flu outbreak. Updates to guidance and policies during the COVID-19 pandemic had reflected wider national guidance and staff had been aware of these changes.

Information management

Record keeping systems were not always easy to use. This had meant data relating to service delivery was not always recorded, accurate or easy to navigate.

The multiple systems used to record, store and collect data within the service did not always work cohesively. We reviewed two incidents where the administration of medication had been incorrectly recorded. We also found one incident that had been detailed in the daily care records of patients but had not been added to the incident reporting system.

It was difficult for staff to find information within the different systems. There had been some incidents where the most up-to-date information regarding a patient's care had not been communicated to nursing staff.

The provider did not always submit accurate information to external bodies. For example, an allegation of verbal abuse made by a patient had not been reported to the local authority or to the CQC. Providers are legally required to submit notifications about these kind of incidents under The Care Quality Commission (Registration) Regulations 2009.

However, managers had access to information relating to the operational performance of the service and used it to support them with their management role. This included information on the financial performance of the service, staffing and delayed discharges. Managers reviewed this information at monthly governance meetings with senior members of the multidisciplinary team.

Information governance systems included confidentiality of patient records. There was a clear policy in place regarding the use of CCTV that respected patient's dignity. Staff working within the service were unable to view this footage unless requested by senior managers.

Engagement

Engagement with patients, carers and staff had improved. Further work was needed to improve communication with external agencies involved in patients' care.

Staff and patients had access to up-to-date information about the work of the provider and the services they used. Team meetings at ward level had been re-established where staff received key updates about the service. Patient council meetings took place on a monthly basis, as well as weekly community meetings on each ward.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The interim management team had recently organised an Expert by Experience event to gather feedback from patients on recent changes within the service.

Some families and carers we spoke to were not aware of the recent management changes, this included carers who were involved with patients' care and treatment. Staff had recognised carer engagement was an area for improvement. A carers forum had been introduced to engage with the family and carers of patients.

Managers used feedback from patients and staff to make improvements.

Patients were involved in decision-making about changes to the service. For example, staff had recently worked with patients to mutually agree ward expectations in relation to the day to day running of the ward. The interim management team were keen to further patient and carer involvement in the decisions about the service. This included patients joining the interview panel for potential new staff moving forward.

Leaders had not always engaged with external stakeholders such as commissioners in a proactive way. Staff had not always updated patients' care coordinators or commissioners about significant changes to individual patients' care and treatment. The interim management team had identified this as an area for improvement and had started to re-establish communication lines with the relevant stakeholders.

Learning, continuous improvement and innovation

In response to challenges the service had faced in the last twelve months, senior staff had decided to pause quality improvement activity on site. This meant staff had not had opportunities to participate in research or complete quality improvement projects. We did not find that innovations were taking place in the service. Staff had not participated in national audits or quality improvement initiatives relevant to the service.

This decision had been made to allow staff time to prioritise immediate service delivery and upskill new staff. The provider had arranged a schedule of monthly bitesize training sessions in specific areas such as physical health, communication and problem solving for new members of staff.

The different Hospital Directors and Clinical Leads that had been in post had also been able to attend internal steering groups with other personality disorder services. Senior members of staff had outline plans to achieve the 'Enabling Environment' accreditation with the Royal College of Psychiatry but this had not yet been achieved.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that all incidents, including safeguarding concerns had been reported, investigated and any learning embedded to mitigate potential future risks. The provider had sometimes failed to share information regarding incidents with external bodies in a timely way.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance There had not been a consistent and effective management team in place for some time. This leadership team had not ensured robust governance processes were implemented on site and had not provided full support to staff; this included the completion of regular supervisions.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance Record keeping systems did not always enable staff to maintain an accurate, complete and contemporaneous record of each patient's care. Records were not always accessible to staff. This included records kept in relation to the patient's medication and risk profile.