Cygnet Health Care Limited

Acute wards for adults of working age and psychiatric intensive care units

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	Chamberlain and Orchid 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

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Summary of findings

Overall summary

- Identified risks were being managed appropriately. For example, the fixtures and fittings associated with curtain rails had 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. Staff reported receiving effective training opportunities.
- Assessments took place using the short term assessment of risk and treatability. Discharge planning started on admission as patients could be transferred back to their placing NHS trust at short notice.
- Different professions worked effectively to assess and plan care and treatment programmes for patients. Staff would work collaboratively with the placing NHS trust to plan effective transfers of care.
- We saw good examples of effective staff and patient interaction and individual support being provided. An emphasis upon least restrictive practice was noted wherever possible. The provider had a clear complaints policy and good procedures for complaint investigation and for complainants to be given a response.
- The hospital had produced a 'welcome pack' for patients who were admitted to help orientate them to the hospital. These wards reported a large number of admissions and discharges over a month. Admissions were triaged by the shift co-ordinator in conjunction with responsible clinician. The length of stay on these wards ranged from less than 24 hours to three months. The wards had a dedicated social worker and they liaised closely with patients' families and with statutory agencies as applicable.
- Most staff were aware of the provider's vision and values. Evidence was seen that regular unannounced visits took place by senior managers. These included night visits. 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 in the service and staff approached them to raise concerns.
- Both wards were working towards obtaining the accreditation for in-patients mental health service.

However:

- Four of the ten care and treatment records we reviewed did not make reference to a Care Programme Approach meeting where relevant.
- 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.
- 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.

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. For example, the fixtures and fittings associated with curtain rails had been changed to reduce any potential self-ligature risk.
- 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.
- 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. 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.

Are services effective?

- The care plans that we reviewed were personalised and sufficiently detailed to ensure staff understanding and consistency of approach. Assessments took place using the short term assessment of risk and treatability. Discharge planning started on admission as patients could be transferred back to their placing NHS trust at short notice. Evidence was seen of collaborative working with the placing NHS trust and effective transfer planning as part of this process. A physical health care facilitator was employed by the hospital.
- Staff reported receiving effective training opportunities and 100% of staff were on target to complete their annual mandatory training programme. Different professions worked effectively to assess and plan care and treatment programmes for patients.
- Patients were aware of the independent Mental Health Act advocacy service. The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice.

However:

- Four assessment and treatment records of the ten reviewed did not make reference to a Care Programme Approach meeting where relevant.

Summary of findings

- Medication stock audits were not assessed by staff against the medicine administration record sheets.

Are services caring?

- 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. Patients told us that staff involved them in their own care.
- The hospital had produced a 'welcome pack' for patients who were admitted to help orientate them to the hospital. We saw effective social worker liaison with families and healthcare professionals from the patients' home area.

However:

- 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?

- These wards reported a large number of admissions and discharges over a month. Admissions were triaged by the shift co-ordinator in conjunction with responsible clinician. The provider reported responsive joint working with placing NHS trusts and this included arrangements for transferring patients in and out of this hospital. The length of stay on these wards ranged from less than 24 hours to three months.
- Clear arrangements were in place to facilitate family visits to the unit. The wards had a dedicated social worker and they liaised closely with patients' families and with statutory agencies as applicable. Staff placed an emphasis upon least restrictive practice wherever possible. Patients' diverse needs relating to religion and ethnicity was recorded and these were being met for example through religious specific diets.
- Examples were seen of advocacy support during clinical reviews where required. The provider had a clear complaints policy and procedure systems for them to be investigated and complainants to be given a response.

Are services well-led?

- Most staff were aware of the provider's vision and values. Staff had access to the provider's intranet and received a weekly hospital newsletter.

Summary of findings

- Senior staff have attended provider away days to discuss the vision and values of the organisation. Key performance indicators were discussed at the trust's monthly clinical governance meeting. For example, safeguarding and incidents and complaints.
- Evidence was seen that regular unannounced visits took place by senior managers. These included night visits. 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 in the service and examples were seen of staff approaching them to raise concerns.
- Both wards were working towards obtaining the accreditation for in-patients mental health service (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards and is managed by the Royal College of Psychiatrists Centre for Quality improvement.

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 staff felt that there was a disconnect between the provider's vision and values and the actions of some senior staff.
- 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 two acute admission and PICU wards at this hospital.

Orchid ward - 14 beds for female patients with 13 in-patients during the inspection

Chamberlain ward - 14 beds for male patients with 13 in-patients during the inspection.

Each patient was detained under the 1983 Mental Health Act.

Care episodes were often short and depended upon the capacity of acute admission beds of the referring NHS trust.

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:

- Visited both wards and looked at the quality of the ward environment and observed how staff was caring for patients.
- Spoke with twelve patients across both 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 and newly appointed hospital director.

Summary of findings

- Spoke with the medical director, two consultant psychiatrists and two associate specialists.
- Spoke with nine frontline staff members including allied healthcare professionals, trained nurses and health care assistants.
- Held six focus groups that thirty-five staff from across the whole hospital attended.

We also:

- Reviewed in detail ten individual assessment and treatment records
- Reviewed 20 prescription charts.
- Examined ten 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 team:

- Spoke with twelve patients across both wards.
- Reviewed 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.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Actions the provider SHOULD take to improve:

- The provider should ensure that all patients receive a care programme approach meeting where relevant.
- 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 some patients is clearly documented.

Cygnet Health Care Limited

Acute wards for adults of working age and psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Chamberlain and Orchid wards	Cygnet Hospital Stevenage

Mental Health Act responsibilities

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

- The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice. 66% of staff across the hospital had received their mandatory MHA training for 2014/2015. Information regarding patient rights under the Act were on display. The records showed that patients had been informed of their rights of appeal against their detention. Patients were aware of the independent advocacy service. Several patients were being supported in applying to the Mental Health Act first tier tribunal to seek a discharge from their section.

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 – Chamberlain and Orchid 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 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 had been changed to reduce any potential self-ligature risk.
- Both ward areas were generally well maintained. Patients told us that the wards were usually kept clean. Dedicated cleaners were employed by the hospital. Staff told us that maintenance requests were promptly addressed where ever possible. Arrangements were in place to support visits by external contractors. Resuscitation equipment was in place and checked regularly to ensure that it was fit for purpose and could be used in an emergency situation.
- Observation whilst patients were using the toilet in Chamberlain's seclusion room had to be undertaken from the seclusion room if required.

Safe staffing

- The hospital has its own bank of qualified and support workers. Agency staff were also used. New permanent, bank and agency staff received an induction to the hospital. Where gaps had been identified within the duty rotas this was being covered by the use of bank and agency staff. Senior managers confirmed that retention and recruitment of staff was a concern. Chamberlain had a vacancy rate of 6% and Orchid a vacancy rate of 27%. Permanent staff sickness rates for Chamberlain were 1.5% and for Orchid 5.5%. 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.
- 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. 13 staff were on duty on Orchid ward and nine on Chamberlain ward. 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. Some patients were on enhanced observation levels following clear risk assessments. 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.
- Staff felt that gaps in permanent staffing levels adversely affected patient care. Some staff raised concerns about the motivation of agency staff members.

Assessing and managing risks to patients and staff

- 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 had received safeguarding training. We found that staff were attending their annual refresher training. Staff 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. Twenty safeguarding incidents had been reported to the Care Quality Commission during 2014 and where required these had been investigated appropriately.
- 70 episodes of long term segregation and seclusion were reported for these wards between July and December 2014. These were closely monitored and audited by the hospital. Staff knew how to report incidents and the provider had clear guidance to staff

Are services safe?

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

on incident reporting. All serious untoward incidents were reviewed daily by senior hospital managers. Staff confirmed that safety alarms worked effectively and there was a prompt response should concerns be raised.

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.

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 – Chamberlain and Orchid wards

Assessment of needs and planning of care

- Patients had comprehensive multi-disciplinary assessments in place. This included initial 72 hour care plans upon admission. Patients had care plans and personal support plans that were comprehensive and up to date. These care plans were personalised and sufficiently detailed to ensure that staff knew how to care for them.
- A physical health care facilitator was employed by the hospital. Physical healthcare monitoring was taking place for example, monitoring of blood pressure for potential side effects caused by prescribed medication.

Best practice in treatment and care

- Assessments took place using the short term assessment of risk and treatability (START). Staff had identified any concerns with physical healthcare and short term care plans were in place to support these. A range of therapeutic interventions in line with the guidance issued by the National Institute for Health and Care Excellence were provided. These included talking therapies socialisation skills and individual needs assessment. Open 'drop in' mental health awareness groups were held weekly. These offered short term psychological support wherever possible. Discharge planning started on admission because patients could be transferred back to their placing NHS trust at short notice.
- The hospital was 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. Medication stock audits were not assessed by staff against the medicine administration record sheets. Otherwise, medicines were well managed and medicine administration records were completed appropriately.

Skilled staff to deliver care

- Staff received training via a monthly mandatory training week. Staff reported receiving effective training opportunities. 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. Nursing staff received monthly reflective practise training from the psychologists. New staff had an induction programme prior to working on the wards. Monthly training attendance was reported to senior management. Non-attendance was monitored and reported to line managers.
- Staff told us that ward based staff meetings were often postponed due to pressures of work.

Multi-disciplinary and intra-agency team work

- The ward teams comprised a consultant psychiatrist, ward doctor, psychology, and occupational therapy, social work supported by housekeeping, catering, maintenance and administration. Different professions worked effectively to assess and plan care and treatment programmes for patients. Collaborative working with the placing NHS trust and effective transfer planning took place and this was demonstrated by those records seen. Positive links with a local police liaison officer who would visit to meet patients or staff if required were noted.

Adherence to the MHA and MHA code of practice

- The provider had clear procedures in place regarding their use and implementation of the Mental Health Act and the code of practice. 66% of staff had received their mandatory MHA training for 2014/2015. Information regarding patient rights under the Act were on display. The records showed that patients had been informed of their rights of appeal against their detention. Patients were aware of the independent advocacy service. Several patients were being supported in applying to the Mental Health Act first tier tribunal to seek a discharge from their section.

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 – Chamberlain and Orchid wards

Kindness dignity respect and support

- 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. They 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. Evidence was seen of an emphasis upon least restrictive practice wherever possible. For example patients had access to mobile phones and computers.

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. For example, patients said that they could see the responsible clinician in charge of their care at weekly care review meetings, and that they felt their views were listened to. Advocates were available on the unit and there was information available about access to advocacy services.
- 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. 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. There was effective social worker liaison with families**.** We found that four 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 – Chamberlain and Orchid wards

Access discharge and bed management

- These wards reported a large number of admissions and discharges over a month. There had been a total number of 291 admissions to the hospital in 2014. Chamberlain had average bed occupancy of 90% and Orchid 89%. Initial admission assessments were seen. Admissions were triaged by the shift co-ordinator in conjunction with responsible clinician. Section 19 authority of transfer paperwork was found to be in order. The provider reported responsive joint working with placing NHS trusts and this included arrangements for transferring patients in and out of this hospital. We found that patients had discharge plans in place following their admission. The length of stay on these wards ranged from less than 24 hours to three months. Two patients on Orchid ward reported delays in their discharge process due to difficulties with finding suitable future placements within their home area.

The ward optimises recovery comfort and dignity

- Access to Mental Health Act section 17 leave was documented. Clear arrangements were in place to facilitate family visits to the unit. Patients had access to a courtyard and a smoking shelter. The wards had access to dedicated social workers and psychologists to improve care and treatment outcomes. A general practitioner visited the hospital once a week to provide physical healthcare interventions where required.

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. Patients told us that the food provided was good. Access to facilities such as the laundry and ward based kitchen was risk assessed. Patients had access to mobile phones and computers. Patients' diverse needs such as religion and ethnicity was recorded and these were being met for example through religious specific diets. There was information available throughout the service for patients and this included information about rights under the Mental Health Act 1983. Examples were seen of advocacy support during clinical reviews where required.

Listening and learning from concerns and complaints

- The provider had a clear complaints policy and procedure. Systems were in place for these to be investigated and for complainants to be given a response. 26 complaints were received in 2014 about these two wards. Five of whom were fully upheld.
- Information was displayed on each ward for patients to provide them with information about making a complaint. There were additional systems for patients to raise issues 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 throughout the service. For example via the hospital's weekly newsletter.

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 – Chamberlain and Orchid wards

Vision and values

- Most staff throughout 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. Staff had access to the provider's intranet and received a weekly hospital newsletter. Senior staff have attended provider away days to discuss the vision and values of the organisation. Recruitment interviews and appraisals both made 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. 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 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

- Both wards were working towards obtaining the accreditation for in-patients mental health service (AIMS). This is a standards-based accreditation programme designed to improve the quality of care in in-patient mental health wards and is managed by the Royal college of Psychiatrists centre for quality improvement.