Cygnet Hospital Colchester

Quality Report

Boxted Road
Mile End
Colchester
Essex CO4 5HF
Tel: 01206 848 000
Website:www.cygnethealth.co.uk

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

This service was placed in special measures in 14 June 2019. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker
Chief Inspector of Hospitals

Overall summary

We rated Cygnet Hospital Colchester overall as 'inadequate' because:

- Until recently the hospital manager did not have a robust management team in place to support them to develop governance system effectively and manage risks in the hospital. The provider had not addressed all risk areas identified from our 2018 and 2019 inspections, such as ensuring staff had regular supervision. The provider needed to improve processes for incident investigations, including sharing learning or actions with staff, duty of candour and, have a quality assurance system to ensure actions were completed. The provider also did not ensure there were systems established and operating effectively for the review or investigation of reported staff restraints on patients. We had concerns that the provider had not given the hospital manager sufficient support and resources to implement the required changes in a timely manner.
- Not all staff treated all patients with kindness, dignity, respect, compassion and support on Ramsey, Oak and Larch Court. We found an example when reviewing CCTV footage for Ramsey ward where staff were seen to be intimidating towards a patient prior to a restraint incident and staff did not follow the patient's management plan. Five of six Oak and Larch patients care plans held limited information about how staff involved patients or carers. This was an issue from our 2018 inspection. Patients on Oak and Larch Court and Highwoods wards did not have robust discharge plans. Staff did not regularly communicate with carers and engage them in the development of the service.
- Staff did not consistently administer medication to patients under the correct legal authority. We identified four errors on Oak and Larch Court where staff had not correctly completed two patients' prescription charts relating to the 'T2' consent to treatment form and had not correctly completed two patients' prescription chart relating to a 'T3' form where they lacked consent to treatment. Highwoods ward needed to make improvements to their recording and storage of mental capacity assessments.
- There was a gap in the leadership presence and oversight on Ramsey ward. The manager had recently left the ward and staff told us the team lacked cohesion. We identified risks for this ward for all domains.
- The provider needed to make improvements to ensure ligature risk assessments were thoroughly completed and Ramsey ward and Oak Court to ensure staff knew how to manage the risks for their wards.
- Staff alarms did not work across wards and it would not be easy to identify if urgent response was needed for another ward.
- Staff on Oak Court did not consistently follow the provider's observation policy. We found 10 examples in

Summary of findings

one week, of staff continuously observing patients for more than two hours. This was not in accordance with the provider's policy and protocol for the management of enhanced observations.

- The provider's systems for communicating risk information between the hospital and board were not fully effective as we found gaps relating to risks on the risk register and the hospital managers reports to the Operations Director.
- Managers on Highwoods and Oak Court did not have easy access to information to support them with their management role, such as training, staff sickness and turnover data. The provider's system for recording staff on shift was confusing. There were inconsistencies in Highwoods ward, Oak Court and Larch Court records.
- The provider had implemented a no smoking policy at the hospital since our April 2019 inspection. However, the provider had not formally reviewed the effectiveness of this with staff and patients. Staff did not routinely record their risk assessment of Highwood patients before they went on leave to smoke outside the hospital. Staff had not developed care plans on Highwoods ward, to support patients with smoking reduction. Highwoods and Ramsey staff said they had difficulties allocating staff to escort patients for leave to smoke, and for searching patients on return to the ward.
- The provider had not ensured that Highwoods patients had regular access to activities. The Joy Clare centre activity programme was not fully operational at the time of the inspection as there were occupational therapy posts vacant. Patients on Highwoods and Oak and Larch Court were dependent on staff to give them access to the kitchenette to make drinks and snacks. The provider needed to make some improvement to the environment on Highwoods ward for staff offices, property storage and the assisted bathroom.
- The provider had not completed a specific assessment of how they were meeting the accessible information standards to meet patients' needs, in line with section 250 of the Health and Social Care Act 2012. The provider's Workforce Race Equality Standard action plan was not specific, measurable, attainable, relevant, and time-based.

However:

- The provider had made notable changes to improve and strengthen the leadership of the hospital in the last 12 months and since our last April 2019 inspection. Oak and Larch Court and Highwoods had newly employed ward managers. The majority of staff told us the management structure of the hospital improved and they felt more confident in their ability to lead and improve the hospital. The provider had closed Flower Adams wards following our inspection in April 2019 where we identified a number of risks and imposed conditions on the provider's registration to restrict admissions.
- The provider had acted since our April 2019 inspection, to ensure there were sufficient staff to meet patient's needs; that staff received essential training (including restraint) and that agency staff had checks before working at the hospital. The provider had employed a staffing coordinator lead on these improvements. The hospital manager now employed a governance assistant and other staff to help them with implementing processes and was in the process of advertising for quality assurance staff posts.
- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff identified patients' physical health needs and recorded them in their care plans.
- Twelve of 13 patients across all wards said staff treated them well and behaved kindly. Highwoods and Ramsey staff involved patients in developing their care plans and risk assessments.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care (clinic room to examine patients, activity and therapy rooms).

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	Highwoods Ward has 19 beds and is an acute in-patient service. The service is new and opened on 16 September 2019.
Long stay or rehabilitation mental health wards for working-age adults	Inadequate 	Ramsey ward has 21 beds and is a high dependency inpatient rehabilitation service.
Wards for people with learning disabilities or autism	Requires improvement 	Oak Court has 10 beds for men with a learning disability, associated complex needs and behaviours that challenge. Larch Court has four beds and provides intensive support for men with autism, learning disabilities and complex needs.

Summary of findings

Contents

Inadequate

Cygnet Hospital Colchester

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working-age adults; Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Cygnet Hospital Colchester

The location Cygnet Hospital Colchester is a 54-bed hospital for men aged 18 years and above based in Colchester, Essex. The provider is Cygnet Learning Disabilities Ltd.

There are three core services:

Acute wards for adults of working age

- Highwoods Ward has 19 beds and is an acute in-patient service. The service is new and was opened on 16 September 2019.

Summary of this inspection

Long stay rehabilitation mental health wards for working age adults

- Ramsey ward has 21 beds and is a high dependency inpatient rehabilitation service

Wards for people with a learning disability or autism

- Oak Court has 10 beds for patients with a learning disability, associated complex needs and behaviours that challenge. Four beds are for patients in short term crisis admissions or those who no longer require acute care but remain on an acute ward. Five beds are for patients with high dependency needs and supports assessment, treatment and rehabilitation. There is a one bed apartment to provide a more independent living environment.
- Larch Court has four beds and provides intensive support for patients with autism, learning disabilities and complex needs

Clinical teams give multidisciplinary input to both wards including nursing, occupational therapy, psychology, psychiatry and vocational training. The hospital has an off-site activity centre (Joy Clare).

This location is registered with the Care Quality Commission 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.

The location has a registered manager (who is also the controlled drugs accountable officer).The Care Quality Commission carried out a focused inspection on Flower Adams 1 and 2 wards at this location on 9, 15 April and 2 May 2019. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for:

- Regulation 12 safe care and treatment
- Regulation 17 good governance
- Regulation 10 Dignity and respect

The CQC placed urgent conditions on the location's registration and also issued a warning notice and requirement notices. The CQC placed the location in special measures. The provider has sent the CQC their action plans outlining how they would address the breaches of regulations. They have now closed Flower Adams wards and the CQC have removed the conditions.

The last comprehensive CQC inspection of this location was 13 to 14 November 2018.

Summary of this inspection

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for:

- Regulation 9 person centred care
- Regulation 12 safe care and treatment
- Regulation 17 good governance
- Regulation 18 staffing

At this inspection we found the provider had taken actions to make improvements, but we have identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for:

- Regulation 9 person centred care
- Regulation 12 safe care and treatment
- Regulation 17 good governance

Additionally we identified a breach of Regulation 13 safeguarding service users from abuse and improper treatment and issued a warning notice to the provider.

Our inspection team

The team that inspected the service comprised of four CQC inspectors, an inspection manager, a specialist advisor with a nursing background and two experts by experience.

Why we carried out this inspection

We carried out a comprehensive inspection of this location to check on the provider's actions in response to our April 2019 inspection, as we had placed the hospital in special measures. Additionally we checked on actions from our 2018 inspection. This inspection was unannounced although the provider knew a timeframe for when they would be inspected.

How we carried out this inspection

To fully understand 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 the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients; looked at the Joy Clare unit where activities took place
- spoke with 13 patients who were using the service
- spoke with eight carers whose relatives were using the service
- spoke with the registered manager, operations director, clinical service manager and two ward managers
- spoke with 24 multi-disciplinary staff members; including doctors, nursing, occupational therapy, psychology staff, plus seven others including, safeguarding, mental health act, administration, housekeeping and advocacy staff
- looked at 21 care and treatment records of patients
- looked at the provider's records for 28 staff (permanent, bank and agency)
- attended and observed four morning staff shift hand-over meetings and two situation reporting meetings, plus a multi-disciplinary review meeting with a patient
- received feedback from one stakeholder

Summary of this inspection

- carried out a specific check of the medication management on wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Twelve of 13 patients across all wards said staff treated them well and behaved kindly. Three Highwood patients told us they had witnessed or experience violence or aggression from other patients. Two said they would like more activities and more access to snacks and drinks. Three Oak and Larch Court patients told us they liked the food.

Six of eight carers we spoke with were pleased with the quality of care staff gave overall. Five carers told us that staff did not routinely keep them updated on their relatives' care or provide carer's information. Four told us their relative needed more support such as with managing their personal hygiene. Two carers said staff needed to support patients to manage their weight more effectively. One carer said staff needed to support their relative to sleep less and one carer said their relative had been aggressive following provocation by staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as 'inadequate' because:

- Staff did not report all incidents appropriately on Ramsey and Highwoods ward. The provider still needed to make improvements to improve the quality of incident investigations. The provider had not established a system to review incidents following staff restraints on patients. Staff did not follow one patient's management plan to remove the patient to their bedroom or quiet room following a restraint. Additionally the provider needed to improve their actions relating to duty of candour and sharing learning with staff following incidents.
- The provider still needed to make some improvements to reduce environmental risks. The provider's ligature risk assessment identified the removal of ligature points but had not identified clear timeframes for this, for example the replacement of some windows on Highwoods. The provider had not recorded completed actions on Ramsey ward. Staff had not identified some ligature anchor points on their assessment of Highwoods ward. The provider had not ensured on Ramsey ward and Oak Court that staff had sufficient knowledge of how to manage ligature risks for patients.
- Staff alarms did not work across wards and it would not be easy to identify if urgent response was needed for another ward. The provider needed to make some improvement to the environment on Highwoods ward, for example, staff offices, property storage and the assisted bathroom.
- The provider's system for recording staff on shift needed improvements as we found inconsistency in recording scheduled staff on shift on duty rotas and the actual staffing record on Highwoods ward, Oak Court and Larch Court.
- Staff were not routinely recording their risk assessment of Highwood patients before they went on leave to smoke cigarettes outside the hospital as there was a no smoking on site policy. Highwoods and Ramsey staff said they had difficulties allocating staff to escort patients out to smoke and for searching patients on return.
- Staff on Oak Court did not always follow the provider's observation policy as we found 10 examples in one week of staff continuously observing patients for more than two hours. This could impact on their ability to observe patients safely.

However:

Summary of this inspection

- Staff used a nationally recognised risk assessment, the Short-Term Assessment of Risk and Treatability tool.
- The provider had developed a staff toolkit for 'making safeguarding personal' within the hospital and had developed information folders on wards for staff to reference. These held information such as newsletters including a seven-minute briefing for example about self neglect, coercion, the dark web and county lines.
- Wards complied with guidance on eliminating mixed-sex accommodation as the hospital was for male patients only.
- Clinic rooms were mostly fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff had easy access to clinical information both paper-based and electronic.

Are services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- Managers did not always provide staff with sufficient levels of supervision on Oak and Larch Courts and Ramsey ward. On review of staff's recorded supervision dates on the supervision tracker we found gaps in records and examples of supervision records seen had mostly 'cut and pasted' information within them so was unclear how the session was individual for the staff member.
- Ramsey ward's established psychological programme had not been fully operational for three weeks at the time of our inspection. The ward was waiting for a new psychologist to start working at the hospital.
- Staff had not developed care plans on Highwoods ward, to support them patients smoking reduction.
- Staff did not consistently administer medication to patients under the appropriate legal authority. We identified four errors on Oak and Larch Court where staff had not correctly completed two patients' prescription charts relating to the 'T2' consent to treatment form and had not correctly completed two patients' prescription chart relating to a 'T3' form where they lacked consent to treatment.
- Highwoods ward needed to make improvements to their recording and storage of mental capacity assessments.

However:

Summary of this inspection

- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff identified patients' physical health needs and recorded them in their care plans.
- Staff supported patients through individual and group cooking sessions and provided an independent living skills group at the Joy Clare centre.
- The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- The psychology team held had weekly reflective practice sessions for ward staff.
- Oak Court had identified actions to improve staff's monitoring of patients' deprivation of liberty safeguards applications following an incident.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Are services caring?

Requires improvement

We rated caring as 'requires improvement' because:

- The provider needed to make improvements to ensure staff treated all patients with kindness, dignity, respect, compassion and support. We found an example when reviewing CCTV footage where Ramsey ward staff's body language towards a patient was seen to be intimidating.
- Six carers of patients on Ramsey, Oak and Larch Court told us their relative needed more staff support, for example to manage their personal hygiene. On Oak Court we observed some staff passively observing patients rather than engaging with them.
- Five of six Oak and Larch patients care records held limited information about how staff involved patients or carers in developing care plans. The provider had not fully addressed this after our 2018 inspection. Six carers of patients on Ramsey, Oak and Larch Court said that staff did not routinely keep them updated on their relatives' care or provide information for carers.

However:

- Twelve of 13 patients across all wards said staff treated them well and behaved kindly.

Summary of this inspection

- Highwoods and Ramsey staff involved patients in developing their care plans and risk assessments.
- Highwoods staff supported patients who arrived without possessions to access toiletries or clean clothes.

Are services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- The Joy Clare centre activity programme was not fully operational at the time of the inspection as there were occupational therapy posts vacancies.
- Staff had not fully completed discharge plans for patients on Oak and Larch Court and Highwoods wards.
- Several patients were not from the local area. Some patients were over 50 miles away from their homes. We considered this would be difficult for patients to keep in contact with family and friends.
- The provider had not completed a specific assessment of how they were meeting the accessible information standards to meet patients' needs, in line with section 250 of the Health and Social Care Act 2012.
- The provider had limited information available relating to response to complaints before April 2019. It was unclear whether the provider was compliant with its complaint's policy prior to this time.

However:

- The provider had a system for quickly assessing patients' suitability for the ward prior to admission. This included senior staff oversight out of usual working hours.
- Ramsey patients had the opportunity to participate in therapeutic jobs within the hospital and at the Joy Clare activity centre. Roles consisted of caretaker jobs, lunch time assistants, litter pickers and a tuck shop controller and buyer.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. Staff had displayed patient information using 'widget symbols ' such as to help patients identify pain, mood and wellbeing.

Are services well-led?

Inadequate

We rated well-led as 'inadequate' because:

- Until recently the hospital manager did not have a robust management team in place to support them to develop governance system effectively and manage risks in the hospital.

Summary of this inspection

Some actions identified from our 2018 and 2019 inspections still needed further action. The provider needed to make improvements to processes for incident investigations, to include share learning or actions with staff, improve their duty of candour, and have a quality assurance system to ensure actions were completed. The provider had not ensured there were systems established and operating effectively for the review or investigation of reported staff restraints on patients. We had concerns that the provider had not given the hospital manager sufficient support and resources to implement the required changes in a timely manner.

- Managers did not ensure staff on Ramsey ward, Oak Court and Larch Court received sufficient levels of supervision. There was a gap in the leadership presence and oversight on Ramsey ward. The manager had recently left the ward and staff told us the team lacked cohesion. We identified risks for this ward regarding the safe, effective and caring domains.
- The provider had not ensured ligature risk assessments were thoroughly completed. Ramsey ward and Oak Court staff did not fully know how to manage the risks for their wards.
- The provider's systems for communicating risk information between the hospital and board were not fully effective. This posed a risk that the provider's board would not have sufficient oversight of the risks at the hospital, or the level of support needed to make improvements.
- Highwoods and Ramsey ward managers did not have easy access to information to support them with their management role, such as training, staff sickness and turnover data. The provider's Workforce Race Equality Standard action plan was not specific, measurable, attainable, relevant, and time-based.
- The provider had implemented a no smoking policy at the hospital since our April 2019 inspection. However, this had not been reviewed with staff and patients to ensure it was implemented effectively. The provider had not ensured that patients on Highwoods ward had regular access to activities. Improvements were needed to engage carers in the development of the service.

However:

- The provider had closed Flower Adams wards following inspection in April 2019, where the Care Quality Commission identified a number of significant risks to patient safety. Managers held consultations with staff about the closure of Flower Adams wards, the change of name to Highwoods ward, and the plans for a change of service provision to an acute admission ward for males experiencing a mental health crisis.

Summary of this inspection

- The provider had acted since our April 2019 inspection, to ensure that staff received essential training (including restraint) and that agency staff had checks before working at the hospital. The provider had employed a staffing coordinator to lead on this.
- The hospital manager had developed some ways to help communicate key information to staff such as through monthly staff and safeguarding newsletters. The hospital manager now employed a governance assistant and other staff to help them with implementing processes and was in the process of advertising for quality assurance staff posts.
- The provider had made some changes to improve and strengthen the leadership of the hospital in the last 12 months and since our April 2019 inspection. Oak and Larch Court and Highwoods had newly employed ward managers.

Detailed findings from this inspection

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.

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

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Mental health administration staff gave feedback if staff had missed detention paperwork errors. The provider had given staff training for this and a checklist to help reduce the risk of this.

The provider displayed a notice to tell informal patients that they could leave the ward freely and patients signed a contract agreeing to their admission. The provider had systems in place for staff to request mental health assessments if they had concerns about informal patient's capacity to give consent.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. However, the provider's tool was not fully applicable for Highwoods as staff did not scrutinised detention papers before accepting the patient for admission. Also the audit did not check that staff had easy access to the approved mental health practitioner's reports. Whilst administrators had a system to request these we did not see them in the patients records on Highwoods ward.

Staff did not consistently administer medication to patients under the correct legal authority. We identified four errors on Oak and Larch Court where staff had not correctly completed two patients' prescription charts relating to the 'T2' consent to treatment form and had not correctly completed two patients' prescription chart relating to a 'T3' form where they lacked consent to treatment. Staff requested an opinion from a second opinion appointed doctor when necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act 2005.

There were no patients subject to deprivation of liberty safeguards when we visited.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Staff took all practical steps to enable patients to make their own decisions.

Detailed findings from this inspection

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies.

The service had arrangements to monitor adherence to the Mental Capacity Act.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. However, Highwood's staff could not locate an assessment for patient where they had identified the patient required urgent medical treatment for their physical health. Additionally another assessment held limited details regarding a best interest decision. We saw examples on other wards where staff assessed patients' mental capacity. Staff had reported an incident for Oak Court relating to a patient subject to deprivation of liberty safeguarding and staff's oversight and monitoring of this application was not robust. The provider had conducted an investigation and staff learning to reduce the risk of reoccurrence. We saw administrators had a tracker in place to monitor applications and expiry dates.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Wards for people with learning disabilities or autism	Inadequate	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

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

Requires improvement

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

The ward was not purpose built for this patient group but had been adapted and refurbished before opening. The ward layout did not allow staff to observe all parts of ward. One corridor area had a blind spot which the manager stated would be updated on the provider's assessment. However, the provider had reduced most blind spots through placing mirrors to improve staff observation. Staff did regular risk assessments of the care environment. However, two records for checks in November 2019 were incomplete.

The provider's ligature risk assessment identified the removal of ligature points but had not identified clear timeframes. For example, for the replacement of some windows. There were some ligature anchor points not identified on the ligature assessment such as in the assisted bathroom furniture. Staff had identified that the cupboards needed removal as there were gaps between doors where ligature items could be inserted.

The ward was on one level. We identified a possible 'foothold' in the garden not on the provider's risk assessment that posed a risk of patients using this to get onto the roof. Staff said there had not been any incidents in the area and staff would supervise patients.

Whilst staff alarms worked on the ward they did not work across wards and it would not be easy to identify if an urgent response was needed for another ward. The provider had identified this risk on the hospital's risk register. Alarms in patients' bedrooms were not easily identifiable. Staff had access to two-way radios if escorting a patient off the ward. During our visit another ward reported an incident where a key had gone missing. The provider reminded staff that key pouches should always be used to reduce this risk. However, we identified there were insufficient key pouches for all staff use.

Both staff offices were not suitable and posed risks to staff and patients. The offices were near the main ward entrance door. We saw this was a high stimulus area as patients congregated around the area especially during multi-disciplinary review times. We saw staff dealing with challenging patients in the office doorways. When we visited staff office temperatures were approximately 30 degrees Celsius. The nursing office had limited space for multiple staff to adequately enter and use. This created an uncomfortable working environment. In contrast staff had identified the conservatory was cold which staff, patients and visitors used. We heard staff talking about needing to wear their coats for warmth when using this room. Staff told us there was a plan to get air-conditioning/heating for these areas but there was not an identified timescale.

The ward property room was cluttered and some patients' toiletries were unsecured which could pose a risk of patients accessing if the door was opened. The manager had identified the potential security risk and had requested purpose-built shelving to improve the space but did not have a timeframe for completion of this work. The communal bathroom had some water damaged cupboard doors and paintwork. One empty bedroom had a musty bathroom smell, but staff said it would be cleaned before

patient admission. However, most ward areas were clean, had good furnishings and were well-maintained. Staff adhered to infection control principles, including handwashing and we saw that regular cleaning took place.

The ward complied with guidance on eliminating mixed-sex accommodation as the hospital and this ward was for male patients only.

The ward did not have a seclusion room. Staff had designated a quiet room/de- escalation room which had heavy furniture and a 'safety pod' specifically for staff to safely restrain patients in if required. Staff understood what the definition of seclusion was and knew that patients should not be prevented from leaving the room.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean.

Safe staffing

The provider could not demonstrate there were sufficient nursing staff deployed to support patients on each shift. We found inconsistency in recording scheduled staff on shift on duty rotas and the actual staffing record. We reviewed a sample of staffing rotas for the previous six weeks and found for the week of 7 October 2019 there were eight discrepancies. One member of staff on training appeared to be counted in the staffing numbers, which had not been identified as a shortfall.

Managers had calculated the number and grade of nurses and healthcare assistants required. When the ward was full there were two registered nurses and five support workers on shift in the day and two registered nurses and four support workers at night. Additionally at night the hospital has a nursing coordinator who worked across wards and was based on Ramsey ward.Information from the provider showed the hospital had eight nurses and 29 support workers vacancies. This ward had three nurse vacancies including a clinical team leader post. Managers had two regular contracted agency staff in place in the interim. The ward had seven permanent nurses.

Staffing levels allowed patients to have regular one-to-one time with their named nurse.The ward manager could adjust staffing levels daily to take account of staff skills and gender mix. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. Information from the provider showed 6% bank and 15% agency staff usage in September 2019 and 3% bank and 19% agency staff usage in October 2019. Staff had reported one incident on 31 October 2019 where there was insufficient time to cover staff illness. Information from the provider showed two unfilled nursing shifts. The ward manager was unable to give us the overall staff percentage for staff sickness or turnover but was able to identify the reasons for staff being on sickness leave or leaving.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The ward had a consultant psychiatrist and speciality doctor. Out of usual working hours, doctors were not based on site. However, staff could contact the on-call speciality doctor and consultant for support.

Most staff had received and were up to date with appropriate mandatory training. Information from the provider showed, 73% of registered nurses and 78% of support workers were compliant. The lowest compliance with mandatory training was 71% for intermediate life support and automated external defibrillator training. However, staff were booked for this training. The ward manager was unable to give us details of individual staff who had not achieved 75% compliance with training.

Assessing and managing risk to patients and staff

Staff did not always identify and respond to changing risks to, or posed by, patients. Staff did not routinely record their risk assessment of patients before they went on leave for example to smoke cigarettes outside the hospital as there was a no smoking on site policy. We found two examples where despite incidents of violence or aggression, the patients had gone off the ward to smoke with other patients on escorted leave. This posed risks to the patient and others. Following our feedback, the hospital manager ensured all patients prescribed section 17 leave arrangements were not specifically prescribed for smoking alone.

Staff did not use the provider's 'daily risk assessment' effectively to identify changes in the patients' risk presentation as we found five examples of where staff had cut and paste most of their entries. However, staff used a nationally recognised risk assessment, the Short-Term Assessment of Risk and Treatability tool.

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

Requires improvement

The provider had policies and procedures for staff observation of patients. We checked a sample of 10 patients' observations records and found three occasions where staff had not recorded their observation of the patient. None of these patients were on enhanced continuous observations. The ward manager had requested staff put more detail when recording their observation of patients to show they were asleep. However, we saw examples where we noted the form did not give much space for staff to give a detailed record.

The ward had a restricted and prohibited items list and search processes. However, we found a patient's belt was left in a locked communal bathroom which could pose a risk to other patients. Highwoods and Ramsey ward used the same room for searching patients, which meant there could be a delay in searching patients if the room was in use.

Staff had restricted all patients access to the kitchenette/servery to prevent causing harm to themselves or others with hot water. Whilst there were no apparent delays with accessing the area, this meant patients would have to ask staff for a hot drink or access to make a drink or snack. Staff individually risk assessed patients for access to their mobile telephones.

Staff used restraint only after attempts at de-escalation had failed. Provider information for September 2019 showed 29 incidents of restraint for all wards. There was no data given for October 2019. The ward staff participated in the provider's restrictive interventions reduction programme. There were no recorded staff restraints of a patient in prone (face down) position. Staff were clear this should not be used. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. However, four of five staff incident reports for administration of rapid tranquilisation did not clearly detail the rationale for why this treatment was required. Although we found that the patient's care plan had identified this as a possible treatment.

There were no recorded incidents of staff using seclusion or long-term segregation with patients.

Staff attended a twice daily situation-report meeting where any incidents were discussed and any changes in risks to, or posed by, patients were responded to.

Safeguarding

Staff were trained in safeguarding and knew how to make a safeguarding alert. Staff worked in partnership with other agencies. The hospital had a process for staff to contact the advocacy service following allegations of abuse, so advocates could meet with the patient. However, this did not routinely happen.

Staff followed safe procedures for children visiting patients and had identified an area off the ward for visits.

The provider had developed a staff toolkit for 'making safeguarding personal' within the hospital and had developed information folders on wards for staff to reference. These held information such as newsletters including seven-minute briefings about self neglect, coercion, the dark web and county lines.

The provider's policy referred to staff receiving safeguarding supervision. We saw that this was a standard supervision agenda item, but we saw limited examples where staff were actively using supervision for discussion of issues.

Staff access to essential information

Staff used more than one recording system, using a mixture of paper and electronic records. This did not cause them any difficulty in entering or accessing information.

Information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. However, staff told us that they could not easily access records if a patient moved from/to another of the provider's locations and we saw this posed a problem for investigators of incidents when they could not gain full access to records to inform their investigation.

Medicines management

We checked 18 patients' medication records and found staff mostly followed good practice in medicines management (such as, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. The ward scored 95% compliance in latest pharmacy audit. However, staff had not fully completed a record for the disposal of medicines and it was not audited.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute

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

Requires improvement

for Health and Care Excellence guidance. The hospital had a contracted pharmacy service which also had arrangements for gaining medication out of hours, including for pain relief or a cold.

Track record on safety

Information from the provider from April to October 2019, showed 43 serious incidents requiring investigation across wards. There was one for this ward, which had opened in September 2019.

Reporting incidents and learning from when things go wrong

Not all staff recognised incidents and reported them appropriately. We found an incident in the patient records which was not formally reported as an incident, nor was it documented in staff shift handover notes as discussed with staff.

The provider had a system for checking and improving the quality of staff's completion of incident reports, but it did not capture the feedback given to staff nor did it and identify any themes and trends for staff learning and development .

We checked a sample of 10 incident investigation reports for this core service written since May 2019. One related to Highwoods and the others were relevant for this core service as they related to the now closed Flower Adams 1 ward. The provider had developed a quality assurance process since April 2019 to help improve the standard of investigation reports. However, we found the quality of reports still varied. Seven reports did not identify risks and actions to reduce the risks of similar incidents reoccurring. We found staff used different templates with different layouts and prompts for information. The hospital manager said they had asked for most incidents to be investigated as a serious incident until they could be assured their incident investigation systems were robust. Eight reports did not fully identify if the provider had met the duty of candour requirement. Duty of candour is a legal obligation for providers to be open and transparent, and to give patients and families a full explanation if and when things went wrong. From an audit of four incident investigation reports across the hospital one had achieved 100%. However, another achieved 40% compliance. It was unclear how the provider had used this information to improve future reports. An incident investigation action recommended 'simulation exercises' to take place. After the site visit, the provider sent us an example of these for 18 October 2019.

The provider had acted since our focused inspection in April 2019 to reduce the backlog of incidents requiring investigation and had a tracker document to monitor this. Wards had 'lesson learnt' folders and staff received emails. Staff supervision and team meetings had learning from incidents as a standard agenda item.

The provider had given senior staff root cause analysis training to help support them with incident investigations The hospital manager was seeking further bespoke training for this. We saw examples of staff and patients having debriefs after incidents such as restraint. Psychology staff were available to support staff after serious incidents. We saw examples where staff discussed potential risk issues for the ward including sexual safety and medication errors. Ward staff gave an example of learning and taking action following feedback after an issue and improving their communication with teams about patients' discharge.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We checked nine patients records. Staff completed an assessment of the patient in a timely manner at, or soon after, admission. However, the document captured mostly patient's physical health and held limited detail about the patient's mental health. Staff daily notes held more detail. This was acknowledged by ward manager and we saw that staff had raised concerns about the amount of admission paperwork they had to complete.

Staff assessed patients' physical health needs. Staff developed care plans that mostly met the needs identified during assessment. Staff updated care plans when necessary.

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

Requires improvement

Care plans were personalised, holistic and recovery-oriented. At times patients may not be known to mental health services prior to admission. Therefore, staff may have limited assessment information and were reliant on the patient or others giving them information.

Best practice in treatment and care

The ward had identified psychology staff who provided some low-key psychology groups suitable for the patient group. The psychology team had a therapeutic directory and interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Staff said it was difficult to engage acutely unwell patients in structured groupwork.

Staff ensured that patients had access to physical healthcare, including access to specialists when needed. The hospital was recruiting a new physical healthcare lead. Staff could arrange for patients to see a GP, who visited the hospital twice a week.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff supported patients to live healthier lives – for example, through participation healthy eating advice, managing cardiovascular risks and dealing with issues relating to substance misuse. However, staff had not developed care plans for five patients, to support patients with smoking reduction.

Staff used recognised rating scales to assess and record severity and outcomes (for example, Health of the Nation Outcome Scales).

The ward did not have a dedicated occupational therapist but had some access to occupational therapy staff and aimed for a minimum of one hour a day. Staff had developed 'grab and go' boxes for the nursing team to deliver some activities, but these were not used.

Skilled staff to deliver care

The team included or had access to doctors, nurses and psychology staff. The provider had a hospital social worker and an occupational therapist post advertised.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff with appropriate induction (using the care certificate standards as the benchmark for healthcare assistants). Managers ensured that staff had access to regular team meetings.

The ward nursing team were newly established although some staff had previously worked on other wards within the hospital including the Flower Adams wards. Latest information from the provider showed 74% staff had supervision in October 2019 and 54% in September 2019. The provider's standard was for staff to have supervision once every three months, but the hospital manager had requested staff have management supervision monthly. Four staff had no recorded data. Two of 11 (18%) staff in post before the ward opened were not having regular supervision. We sampled staff supervision records and found one of 14 records were not available and ten had mostly 'cut and pasted' information so it was unclear how the session was relevant to the individual staff member. We requested regular agency staff supervision records and were only provided with one staff's record and it was not apparent they had regular supervision. The lead psychologist had started staff weekly reflective practice sessions for ward staff in November 2019.

Doctors and psychology staff said they could access specialist training within the organisation and had arrangements for peer and line management supervision.

Managers ensured that staff received the necessary training for their roles. We noted that several staff had completed training to work with patients with a personality disorder when they worked on the Flower Adams wards. However, there was not specific training for Highwoods staff, to work with this patient group despite patients admitted with this diagnosis. This could pose a risk that staff would not be confident to work effectively with all patients.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. The ward team had effective working relationships, including good handovers, with other relevant teams within the organisation (for example, care co-ordinators, community mental health teams, and the crisis team).

The ward team had effective working relationships with teams outside the organisation (for example, local authority social services and GPs).

Staff shared information about patients at effective handover meetings within the team (for example, shift to shift).

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

Requires improvement

Adherence to the MHA and the MHA Code of Practice

The provider had 16 patients detained under the Mental Health Act 1983/2007 and two informal patents on 12 November 2019.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. Administrators had links with other provider locations to gain/give support.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. Mental health administration staff gave feedback if staff had missed detention paperwork errors. The provider had given staff training for this and a checklist to help reduce the risk of this.

The provider displayed a notice to tell informal patients that they could leave the ward freely and patients signed a contract agreeing to their admission. The provider had systems in place for staff to request mental health assessments if they had concerns about the patient's capacity to give consent.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The latest audit on 24 October 2019 showed 98% compliance. However, we noted the provider's tool was not fully applicable for Highwoods as staff did not scrutinise detention papers before accepting the patient for admission. Also the audit did not check that staff had easy access to the approved mental health practitioner's reports. Whilst administrators had a system to request these we did not see them in the patients records on this ward.

Good practice in applying the MCA

Staff had a good understanding of the Mental Capacity Act 2005.There were no patients subject to deprivation of liberty safeguards on this ward when we visited. The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from regarding the Mental Capacity Act, including deprivation of liberty safeguards. Staff took all practical steps to enable patients to make their own decisions. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. However, staff could not locate an assessment for a patient where they had identified that the patient required urgent medical treatment for their physical health. Additionally another assessment held limited details regarding a best interest decision.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

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

Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Two of three patients and one carer we spoke with were positive about the care staff gave on the ward. Two patients said they would like more activities.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Staff supported patients who arrived without possessions to access toiletries or clean clothes.

Involvement in care

Staff used the admission process to inform and orient patients to the ward and to the service. Staff involved patients in care planning and risk assessment.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff enabled patients to give feedback on the service they received (for example, via surveys or community meetings). We saw 13 patient forms which gave feedback on the service. They all gave positive feedback about staff and the ward .

We did not see examples of staff supporting patients to make advance decisions (to refuse treatment, sometimes called a living will).

Staff ensured that patients could access advocacy.

Staff informed and involved families and carers appropriately and provided them with support when needed. We saw examples of carers attending multi-disciplinary review.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

The provider had a system for quickly assessing patients' suitability for the ward prior to admission. This included senior staff oversight out of usual working hours. Staff told us that patients were often admitted in crisis such as via places of safety such health-based places of safety or A&E. Commissioners or the provider could access specialist secure transport and escorts if required as part of admission arrangements.

Due to the nature of the ward the number of beds occupied by patients fluctuated during our visit. The average length of stay since opening was 11 days. At times commissioners moved patients between hospitals during an admission episode if a hospital bed became available in their home area.

The majority of patients were not from the local area, with approximately 50% placed over 50 miles away from their homes. We considered this would be difficult for patients to keep in contact with family and friends. Staff, patients and carers gave examples of arrangements to keep in touch with local areas such as arranging home visits.

When patients were moved or discharged, managers ensured this happened at an appropriate time of day. However, patients could be admitted at any time. We saw examples where staff, in liaison with commissioners had referred patients to a psychiatric intensive care unit (PICU) if a patient required more intensive support. There were no patients with a delayed discharge. We saw that staff developed discharge plans with patients. However we considered these could be more detailed to identify the patient's residence or if they were homeless. Staff told us they would not discharge a patient if they were homeless and had no identified community address to go to.

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

Requires improvement

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms which they could could personalise. Staff and patients had access to the full range of rooms and equipment to support treatment and care (clinic room to examine patients, activity and therapy rooms).

There were quiet areas on the ward and a room where patients could meet visitors. Patients could make a phone call in private. Patients had access to outside space.

Patients' engagement with the wider community

Joy Clare centre included a recovery college with an established programme of sessions to support patients with their access to educational courses and working opportunities. The programme was not fully operational at the time of the inspection but would recommence once all recently recruited occupational therapy assistants were in post. Patients were still able to complete curriculum vitae and were supported to look for volunteering and job opportunities. However, staff told us not all patients were able to go off the ward to attend the centre due to being acutely unwell or not being prescribed section 17 leave to leave the hospital.

Meeting the needs of all people who use the service

The service made adjustments for patients with mobility difficulties – for example, by ensuring access to premises and by meeting patients' specific communication needs.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Staff made information leaflets available in languages spoken by patients.

However, the provider had not completed a specific assessment of how they were meeting the accessible information standards to meet patients' needs. There is a requirement of all providers of NHS care and publicly-funded adult social care to follow the Accessible Information Standard in full of 1 August 2016 onwards - in line with section 250 of the Health and Social Care Act 2012.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Staff supported patients as relevant to return to their home country.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

The provider had a multi-faith room. Patients could request spiritual support, but staff tried to support patients to access local faith groups. However, were still developing contacts for this.

We saw staff considered patients' protected characteristics in line with The Equality Act 2010, such as age; disability; race; religion or belief and sex, for example considering the needs of transgender patients.

Listening to and learning from concerns and complaints

Information from the provider showed the hospital had received 10 compliments from May 2019 The hospital had received 20 complaints since January 2019 with 12 relating to 'therapeutic intervention'. Improvements were needed to demonstrate managers were sharing learning and feedback following complaints to improve the service. (This ward opened in September 2019).

Information was limited about how the provider had responded to these complaints before April 2019. However, we saw there was a system in place since then to monitor and track complaints. Patients knew how to complain or raise concerns. We saw 'you said we did' boards when we arrived, some were not completed 12 November 2019 when we visited but staff completed these during our visit.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Leadership

The provider had made notable changes to improve and strengthen the leadership of the hospital in the last 12 months and since our last April 2019 inspection. The ward manager was newly employed and had experience of working with this patient group. In addition to the hospital manager in post since April 2019, the provider had newly employed a clinical service manager with relevant experience to help the leadership team. The Operations Director who started working with this hospital in January 2019 worked across several hospital and locations, visited weekly and was accessible. A new interim medical director

started in November 2019. The majority of staff told us the management structure of the hospital was much improved and they felt more confident in their ability to lead and improve the hospital.

The hospital manager said they additionally received leadership support from the provider's corporate central team such as the head of clinical risk who was on site when we visited 20 November 2019. Additionally other senior staff such as the managing director and director of nursing had visited. However, most ward staff were not aware of other leaders visiting to support the hospital. We had concerns that the provider had not given the hospital manager sufficient support and resources to implement the required changes in a timely manner.

Vision and strategy

Staff knew the provider's vision and values. The provider's values were based on 'integrity, empower, respect, care and trust'. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Most staff told us the provider had involved them and held consultations about the change of the ward's purpose from supporting women with a diagnosis of personality disorder to instead support men with acute mental health difficulties.

Culture

Most staff felt respected, supported and valued. Most felt able to raise concerns without fear of retribution. Managers dealt with poor staff performance when needed.

The average staff sickness rate was 5% in September 2019 and 2% October 2019 this was similar to the national NHS staff average (4.2% for 2016/2017).

Staff had access to support for their own physical and emotional health needs through an occupational health service. The provider recognised staff success within the service – for example, through staff awards.

Senior managers had an awareness of the need to ensure closed cultures did not develop on the ward and hospital. The team culture was developing.

The provider gave us information about their analysis of data and feedback from their staff survey relating to workforce race equality standards for 2018. The provider's action plan was not specific, measurable, attainable, relevant, and time-based.

Governance

The provider had not fully addressed risk areas from our 2019 inspection, for example relating to sufficient incident investigations, have a system to share learning or actions with staff and, have a quality assurance system to ensure actions were completed. Additionally we found improvements were needed to ensure that audit action plans, had identified timeframes for completion and an effective system to monitor staff on duty was embedded.

The provider's framework of what must be discussed in team meetings at a ward, team or directorate level, such as learning from incidents and complaints, was not yet fully embedded. Until recently the hospital manager did not have a robust management team in place to support them to develop governance systems effectively and manage risks in the hospital.

A number of administration team had left employment. The hospital manager now employed a governance assistant and other staff to help them with implementing processes and was in the process of advertising for quality assurance staff posts. Governance meetings now included ward/team meetings, patient safety, senior management, quality and compliance and health and safety groups. Managers carried out night spot checks of staff competency.

The hospital manager had developed some ways to help communicate key information to staff such as through monthly staff and safeguarding newsletters. The provider had taken action since our April 2019 inspection, to ensure staff received essential training (including restraint) and that agency staff had checks before working at the hospital.

Management of risk, issues and performance

The provider's processes for communicating information, including risks, between the hospital and the board were not robust. The hospital manager gave verbal and written reports to the operational director each week, but examples seen did not fully capture issues, nor did the hospital and operational risk register (for example relating to the hospital staff alarm system). This posed a risk that the provider's board would not have sufficient oversight of risks or understanding of the level of support the hospital required to implement changes. The hospital manager addressed this during our inspection.

We found seven items were raised in the hospital's senior management meeting in July 2019 but not discussed

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

Requires improvement

further in subsequent meetings despite six of them being ongoing concerns and four rated as high-risk issues. There was limited evidence demonstrating the meetings oversight of this to ensure completion and if the risk had increased/decreased. We managed to track actions for these items but not all had been resolved.

The provider had implemented a no smoking policy at the hospital since our April 2019 inspection. However, the provider had not formally reviewed the effectiveness of this with staff and patients. Highwoods staff expressed concern staff resources taken up escorting patients off hospital premises for smoking and then searching patients on return. Additionally we identified risks with this process. During our inspection the hospital manager developed a protocol to stop patients having leave to smoke outside the hospital gate and away from local residents' homes. However, we saw people still smoking there when we visited on 20 November 2019. We received feedback that patients were not fully consulted about changes to the policy.

The provider had not ensured that Highwoods patients had regular access to activities. Information from the provider showed the amount of therapeutic activity was 73% the week commencing 20 October 2019, 40% the week commencing 27 October 2019 and 31% the week commencing 3 November 2019.

The provider had employed a staffing coordinator since October 2019 who had a lead for ensuring essential checks of bank and agency staff before working on the wards. We found examples of staff details not being updated such as to check professional registration details. However, staff were able to check on this and give assurance there were no identified risks. The corporate provider team centrally approved the agencies the hospital could contact, and we understood they assessed and monitored the provision. We were unable to review these during the inspection.

The operations director attended a monthly regional clinical meeting to highlight risks for this hospital at a more centralised level.

Information management

The provider had some systems to collect data from wards and directorates that were not over-burdensome for frontline staff. However, the ward manager did not have easy access to information to support them with their management role, such as training, staff sickness and turnover data.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records. Staff made notifications to external bodies as needed.

Engagement

The provider's systems for acting on patient and carers feedback to develop the service needed improving. Whilst managers and staff had access to the feedback from patients, there was limited information available about how staff acted to address issues. We saw that had staff recently displayed 'you said , we did' boards and put some information on them during our inspection.

Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. However, it was unclear how the provider engaged carers. The hospital manager identified that communication with carers across the hospital could be improved. They were looking to recruit a social worker to help them with this process. Patients and staff could meet with the hospital manager to give feedback.

The hospital manager and other senior staff leaders engaged with external stakeholders – such as commissioners.

Learning, continuous improvement and innovation

The ward had newly opened and the team was still developing but staff told us they were encouraged to consider opportunities for improvements and innovation. The ward currently did not participate in accreditation schemes relevant to the service.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Inadequate

Are long stay or rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

Staff identified and mitigated most environmental risks. However we found areas for improvement. The provider's ligature risk assessment completed in July 2019 identified how staff should manage or remove ligature points, but staff had not recorded completed actions. Staff did not record the action as complete to cover the gaps between a fitted wardrobe and the wall leading to an overhead cupboard, to cover a piano hinge for one bedroom and to remove an old TV bracket in the quiet lounge. Although staff completed daily ligature checklists of the ward environment, one staff member who had been allocated the role of security nurse on the day of our inspection was unable to describe what a ligature point was. Three members of staff were unable to locate a ligature heat map which had recently been placed in the nursing office to visually inform staff of ligature anchor point risks.

Staff could not easily observe patients in all parts of the wards. Ramsey ward was over two floor levels with bedrooms on each floor. Staff mitigated for this by placing convex mirrors in blind spots to enable staff to observe patients. Patients considered a high risk had bedrooms downstairs and were placed on continuous observations.

Staff had easy access to alarms and patients had easy access to nurse call systems. Whilst staff alarms worked on the ward they did not work across wards and it would not be easy to identify if an urgent response was needed for another ward. The provider had identified this risk on the hospital's risk register. Reception staff had systems to charge and test staff and visitor's alarms.

Ward areas were clean, well maintained and well furnished. However, staff did not know how to lock or open some windows in patients' bedrooms which were either locked or remained open. Staff could not identify which key to use to do this.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed the provider's infection control policy, including handwashing.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.

The ward complied with guidance on eliminating mixed-sex accommodation as the hospital and this ward was for male patients only.

The ward did not have a seclusion room and staff understood what the definition of seclusion was.

Safe staffing

Managers had calculated the number and grade of nurses and healthcare assistants required. Information from the provider showed the hospital had eight nurses and 29 support workers vacancies. This ward had four support workers, two senior staff nurses, one consultant psychiatrist, one ward manager and one ward clerk vacancies. Ramsey ward had a locum consultant psychiatrist in place until the position was permanently filled and the clinical service manager was supporting the ward until the role of ward manager was filled.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers could adjust staffing levels daily to take account of case mix. In comparison to the other wards Ramsey ward's staffing rotas were clear and legible.

Managers deployed agency and bank nursing staff to maintain safe staffing levels. Managers limited their use of agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Information from the provider for May to October 2019 showed this ward's highest use of bank staff was 16% in July and the lowest was 6% in May. The highest use of agency staff was 38% in June and the lowest was 20% in October (there were five occasions when this was over 20%).Managers provided data which showed this ward had the highest amount of 19 unfilled nursing shifts between June 2019 and November 2019. Situation report meetings minutes sampled showed one staffing shift unfilled for 30 October 2019.

Data provided by managers showed that between August 2019 and October 2019, staff sickness ranged between five to nine members of staff taking sick leave due to health related or personal issues. The amount of hours staff had taken on sick leave ranged from a minimum of 11.50 hours (one shift) to 211 hours (18 shifts) per month. However, one member of staff was on long term sickness.

The ward manager could adjust staffing levels according to the needs of the patients. Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Staff had completed and kept up-to-date with their mandatory training. Ramsey ward had achieved 85% compliance.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff updated risks using a daily risk assessment tool. Staff used a nationally recognised risk assessment, the Short-Term Assessment of Risk and Treatability tool.

Staff attended a twice daily situation-report meeting where any incidents were discussed and any changes in risks to, or posed by, patients were responded to.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff said they had difficulties finding staff available to search patients on return from leave as this required two staff members present. Staff randomly used metal detectors to search patients. Staff recorded all searches. Staff completed a risk assessment of all patients prior to using leave out of the hospital.

Informal patients could leave the ward. Staff had placed signs throughout the ward informing patients of this and we observed an informal patient leaving the hospital when they wished to.

The Care Quality Commission received concerning information with allegations of inappropriate staff restraint of patients for this hospital. As a result of this, we checked a sample of restraint incidents against closed circuit television images to check on the accuracy of reporting. We found staff did not follow one patient's management plan to remove them to their bedroom or quiet room following a restraint.

Provider information for April to September 2019 for all wards showed 237 incidents of restraint. Restraint data showed 26 incidents of restraint for this ward (compared to eight for 2018). There was no recorded restraints for September and no data available for October 2019.

The ward staff participated in the provider's restrictive interventions reduction programme. There were no recorded staff restraints of a patient in prone (face down) position. Staff were clear this should not be used. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

Ramsey ward did not have a seclusion room. There were no episodes of seclusion within the last 12 months or recent episodes of long-term segregation.

The hospital had recently become smoke free. Patients were using leave to be able to smoke on the road outside of the hospital and staff were escorting patients with escorted leave to be able to smoke. During our inspection visit, we identified issues with the risk management of this

as one member of staff was sometimes escorting several patients to smoke outside. We were not assured that staff would be able to receive a quick response from colleagues in the event of an emergency or the safety of patients and staff would be maintained. Following feedback from the CQC the hospital manager stopped the practice of staff escorting patients solely for smoking across the hospital.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate.

Staff gave examples of how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. The hospital had a process for staff to contact the advocacy service following allegations of abuse, so that advocates could meet with the patient. However, this did not routinely happen.

Staff followed safe procedures for children visiting patients and had identified an area for this. The provider had developed a staff toolkit for 'making safeguarding personal' within the hospital and had developed information folders on wards for staff to reference. These held information such as newsletters including a seven-minute briefing for example about self neglect, coercion, the dark web and county lines.

The provider's policy refers to staff receiving safeguarding supervision. We saw that this was standard supervision agenda item, but we saw limited examples where staff were actively using supervision for discussion of issues.

The hospital had a safeguarding lead who had been working to improve the quality of safeguarding processes. The safeguarding lead reviewed all incidents and staff were given guidelines on how to complete safeguarding referrals appropriately. The safeguarding lead had developed a central log to track the journey of safeguarding referrals and an investigation tracker .Patients had safeguarding care plans identifying any safeguarding risks and the protection plans in place to maintain their safety. This had significantly improved on Ramsey ward in response to a previous serious incident where a patient's safety was not safeguarded.

Staff access to essential information

Staff used more than one recording system, using a mixture of paper and electronic records. This did not cause them any difficulty in entering or accessing information. Records were stored securely

Information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. However, staff told us that they could not easily access records if a patient moved from/to another of the provider's locations and we saw this posed problems for investigators of incidents when they could not gain full access to records to inform their investigation.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff reviewed the effects of medication on patients' physical health regularly and in line with followed National Institute for Health and Care Excellence guidance. The hospital had a contracted pharmacy service which also had arrangements for gaining medication out of hours, including for pain relief or a cold.

Track record on safety

Information from the provider from April to October 2019, showed 43 serious incidents requiring investigation across wards.

Staff had learnt from a significant serious incident where one patients' risks were not clearly identified within their care plan or risk plans. Managers had worked at improving the quality of care plans and risk plans to incorporate significant and relevant risks and as a result were auditing the quality of patient records. Risk assessment documentation had improved, and a system was in place

Long stay or rehabilitation mental health wards for working age adults

Inadequate

for staff to record patient risks on the daily risk assessment tool and to be updated within the short-term assessment of risk and treatability (START) tool at the multi-disciplinary meeting.

Reporting incidents and learning from when things go wrong

Not all staff reported incidents appropriately. We found staff had incorrectly reported an incident that a patient was violent and aggressive towards staff which led staff to physically restrain the patient to ensure the safety of staff and others. When we reviewed the CCTV footage, the incident report did not correspond with footage and following investigation by the provider had not been completed by staff involved in the incident. Managers had not established an effective system for the review or investigation of reported staff restraints on patients to ensure they were not at risk from abuse and improper treatment. This was despite the provider receiving corporate instruction to review CCTV for all incidents of restraints following a serious incident investigation and learning.

The provider had a system for checking and improving the quality of staff's completion of incident forms, but it did not capture the feedback given to staff nor did it identify any themes and trends for staff learning and development.

Managers did not investigate incidents thoroughly. The quality of incident investigations was poor. We reviewed six investigation reports related to incidents on this ward between April and July 2019 and found that three reports were incomplete and did not demonstrate sufficient quality or depth. For the three reports, the terms of reference were placed in the outcome section of one of the reports, staff were not interviewed as part of the investigation for another report and expected actions as a result of learning from the investigation was not included in the last report. Eleven other reports were relevant for this core service as related to the now closed Flower Adams 2 ward. Nine were incomplete and did not demonstrate sufficient quality or depth, and eight did not fully identify if the provider had met the duty of candour requirements. Duty of candour is a legal obligation for providers to be open and transparent, and to give patients and families a full explanation if and when things went wrong. From an audit of four incident investigation reports across the hospital one had achieved 100% but one achieved 40% and it was unclear how the provider had used this information to improve future reports. An incident investigation action recommended 'simulation exercises' to take place. After the site visit, the provider sent us an example of these for 18 October 2019.

Managers had provided a 'lessons learnt' folder for staff to read where learning from incidents were recorded in a quick to read format. Learning from incidents was demonstrated by the development and use of a pre-leave risk assessment which was consistently being completed. This was developed as result of a serious incident on the ward relating to patient leave. Safety alerts were seen on wards within 'lessons learnt' folders.

Managers had included lessons learnt as part of the agenda for staff supervision. However, staff were not always in receipt of regular supervision. Staff meeting minutes included lessons learnt in minutes and we saw records of minutes where this was discussed and recorded. Psychology staff were available to support staff after serious incidents.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We checked five patients care and treatment records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Patients had access to psychological therapies with an assistant psychologist that included one to one sessions and some psychological groups. However, the ward's psychologist had recently left the hospital and the ward

were waiting for a new psychologist to start. The ward had an established psychology programme in place which would recommence once the psychologist was in post. The psychology team had a therapeutic directory and interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.

Staff recorded the amount of activity hours for patients on Ramsey ward which had 100% compliance. This included a range of activities, including leave outside the hospital.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. The hospital was recruiting a new physical healthcare lead. Staff could arrange for patients to see a GP, who visited the hospital twice a week.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Skilled staff to deliver care

Not all staff had regular line management supervision to ensure they had the skills and knowledge for their role. We had identified this as an area requiring improvement at our 2018 inspection. From analysis of the provider's supervision tracker, we identified that only 60% of staff had received supervision between April to July 2019 and 43% between July to October 2019. We sampled staff supervision records and found mostly 'cut and pasted' information. It was unclear how the session was individual for the staff member.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The provider had a hospital social worker post advertised. Managers gave each new member of staff a full induction to the service before they started work.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

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

Staff shared information about patients at effective handover meetings within the team (for example, shift to shift).

The ward team had good handovers, and effective working relationships with other relevant teams within the organisation (for example, care co-ordinators, community mental health teams, and the crisis team).

The ward team had effective working relationships with teams outside the organisation (for example, local authority social services and GPs).

Adherence to the MHA and the MHA Code of Practice

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

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

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

The provider displayed a notice to tell informal patients that they could leave the ward freely and patients signed a

Long stay or rehabilitation mental health wards for working age adults

Inadequate

contract agreeing to their admission. The provider had systems in place for staff to request mental health assessments if they had concerns about the patient's capacity to give consent.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. showed 95% compliance. However, the audit did not check that staff had easy access to the approved mental health practitioner's reports.

Good practice in applying the MCA

Staff had an understanding of the Mental Capacity Act.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples of capacity assessments for five patients.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with kindness, dignity, respect, compassion and support. We found one example when reviewing CCTV footage where staff's body language towards the patient was seen to be intimidating, as they were standing over the patient when they were seated prior to their restraint. Staff presented as apathetic on the ward. We spoke with three carers and two told us their relative needed more support such as with managing their personal hygiene and sleeping less. However, we spoke with four patients who said staff treated them well and behaved kindly.

Staff supported patients to understand and manage their own care treatment or condition.

Involvement in care

Staff involved patients and gave them access to their care planning and risk assessments. We reviewed five patient care records and found that staff had included patients' views. However, two carers told us that staff did not routinely keep them updated on their relative's care or provide carer's information.

Patients were given a welcome pack which included information about the ward on admission. Staff made sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate. We saw some evidence of this within community meetings where the views of patients were sought when making decision about the ward. Although we received feedback that a patient was unhappy following the change in not being section 17 community leave for smoking.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff

Long stay or rehabilitation mental health wards for working age adults

Inadequate

supported patients to make advanced decisions on their care. We viewed two records where patients had made advanced decisions. Staff made sure patients could access advocacy services.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

Staff planned and managed patients' discharge from hospital. Information from the provider between November 2018 to October 2019 showed the average length of stay for patients on this ward was 205 days. There was a delay in discharging one patient due to a delay in the patient's community care coordinator identifying an appropriate placement.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

When patients went on leave there was always a bed available when they returned. Patients were not moved between wards.

Staff did not move or discharge patients at night or very early in the morning. Staff supported patients with transitioning between services.

Staff planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms which they could personalise. Patients had a secure place to store personal possessions and patients could lock their bedrooms. Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private. The service had an outside space that patients could access easily. Patients could make their own hot drinks and snacks and were not dependent on staff. Patients were encouraged to cook their own food and could access the ward kitchen to do so. However, the hospital had identified that the last refurbishment of the ward could be improved further and had submitted plans to further refurbish the ward in 2020. This included developing the laundry area and creating a garden gym.

Patients' engagement with the wider community

The Joy Clare centre had a recovery college with an established programme of sessions to support patients with their access to educational courses and working opportunities. The programme was not fully operational at the time of the inspection but would recommence once all recently recruited occupational therapy assistants were in post. However, patients were still able to complete curriculum vitae and were supported to look for volunteering and job opportunities. Patients could access and use computers to maintain contact with the wider community and families. However, the Joy Clare Centre was not on the hospital site and was only accessible to patients prescribed section 17 community leave. Patients without prescribed leave accessed ward based activities.

Patients could participate in hospital therapeutic jobs and at the Joy Clare activity centre. Roles consisted of caretaker jobs, lunch time assistants, litter pickers and a tuck shop controller and buyer. Patients were paid for these roles at the minimum wage which was funded by the occupational health department.

Staff supported patients as relevant to understand their right to vote in a general election.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The provider had not completed a specific assessment of how they were meeting the accessible information standards to meet patients' needs. There is a requirement of all providers of NHS care and publicly-funded adult social care to follow the Accessible Information Standard in full of 1 August 2016 onwards - in line with section 250 of the Health and Social Care Act 2012.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We saw staff considered patients' protected characteristics in line with The Equality Act 2010, such as age; disability; race; religion or belief and sex .The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. The provider had a multi-faith room. Patients could request spiritual support and staff tried to support patients to access local faith groups but were still developing contacts for this.

Listening to and learning from concerns and complaints

Improvements were needed to demonstrate managers were sharing learning and feedback following complaints to improve the service. Information was limited about how the provider had responded to complaints before April 2019. 'The hospital had received 20 complaints since January 2019 with 12 relating to issues with 'therapeutic intervention'. Information from the provider showed the hospital had received 10 compliments from May 2019.

Patients knew how to complain or raise concerns. You said we did' boards were seen but were not completed.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Inadequate

Leadership

There was no manager for Ramsey ward at the time of the inspection. We found a lack of leadership presence and oversight on this ward. Staff told us there was a lack of cohesion amongst the staff. The provider had plans to recruit a new manager. The clinical service manager provided support in the interim.

The provider had made notable changes to improve and strengthen the leadership of the hospital in the last 12 months and since our April 2019 inspection. In addition to the hospital manager in post since April 2019, the provider had newly employed a clinical service manager with relevant experience to help the leadership team. The Operations Director who started working with this hospital in January 2019 worked across several hospital and locations visited weekly and was accessible. A new interim medical director started November 2019. The majority of staff told us the management structure of the hospital was much improved and they felt more confident in their ability to lead and improve the hospital.

The hospital manager said they additionally received leadership support from the provider's corporate central team such as the head of clinical risk who was on site when we visited 20 November 2019. Additionally other senior staff such as the managing director and director of nursing had visited. However, most ward staff were not aware of other leaders visiting to support the hospital. We had concerns that the provider had not given the hospital manager sufficient support and resources to implement the required changes in a timely manner.

Vision and strategy

Staff knew the provider's vision and values.

Culture

Some staff told us morale was low. Staff told us the leadership on the ward was not supportive. Senior managers had an awareness of the need to ensure closed cultures did not develop on the ward and hospital. Following feedback from staff, senior managers were planning to make changes to the Oak and Ramsey ward teams.

Data provided by managers showed that between August 2019 and October 2019, staff sickness ranged between five to nine members of staff taking sick leave due to health related or personal issues. The number of hours staff had been absent due to sickness ranged from a minimum of 11.50 (one shift) to 211 (18 shifts) per month. However, one member of staff was on long term sickness due to a work-related injury throughout this time. Manager informed us post inspection that there were no notifiable reports of injuries, diseases and dangerous occurrences. Managers carried out night spot checks on staff competency.

The provider gave us information about their analysis of data and feedback from their staff survey relating to workforce race equality standards for 2018. The provider's action plan was not specific, measurable, attainable, relevant, and time-based.

The provider recognised staff success within the service – for example, through staff awards .

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Governance

The provider had not fully addressed risks identified from our 2018 and 2019 inspections for example, such as ensuring staff compliance with supervision, improvements to incident investigations, ensuring a robust and embedded system to share learning or actions with staff, and development of a quality assurance process to ensure actions were completed. Managers had not ensured the model for rehabilitation care, was fully operational due to vacant psychology and occupational therapy assistant posts.

Managers had not ensured staff understood and were aware of ligature risks on the ward. Staff did not know where the ligature risk heat maps were located on the ward despite this being recently implemented and discussed in team meetings.

Whilst the provider had a framework of what must be discussed at a ward, team or directorate level in team meetings, such as learning from incidents and complaints, the system was not fully embedded. We checked a sample of staff meeting minutes. There was not a standard agenda template across wards.

Until recently the hospital manager did not have a robust management team in place to support them to develop governance system effectively and manage risks in the hospital. A number of administration staff had left employment. The hospital manager now employed a governance assistant and other staff to help them with implementing processes and was in the process of advertising for quality assurance staff posts. Governance meetings now included ward/team meetings, patient safety, senior management, quality and compliance and health and safety groups.

The hospital manager had developed ways to help communicate key information to staff such as through monthly staff and safeguarding newsletters. The provider had taken action since our April 2019 inspection, to ensure that staff received essential training (including restraint) and that agency staff had checks before working at the hospital.

Management of risk, issues and performance

The provider did not ensure that there were systems established and operating effectively for the review or investigation of reported staff restraints on patients. The provider's processes for communicating information, including risks, between the hospital and the board were not robust. The hospital manager gave verbal and written reports to the operational director each week, but examples seen did not fully capture issues, nor did the hospital and operational risk register (for example relating to the hospital staff alarm system). This posed a risk that the provider's board would not have sufficient oversight of risks or understanding of the level of support the hospital required to implement changes. The hospital manager addressed this during our inspection.

We saw that seven items were raised in the hospital's senior management meeting July 2019 but were not discussed further in subsequent meetings despite six of them being ongoing concerns and four rated as high-risk issues. There was limited evidence demonstrating the meeting's oversight to ensure completion and if the risk had increased/decreased. We managed to track actions for these items but not all had been resolved.

The provider had employed a staffing coordinator since October 2019 who had a lead for ensuring essential checks of bank and agency staff before working on the wards. We found examples of staff details not being updated such as to check professional registration details. However, staff were able to check on this and give assurance there were no identified risks. The corporate provider team centrally approved the agencies the hospital could contact, and we understood they assessed and monitored the provision. We did not see evidence of this.

The operations director attended a monthly regional clinical meeting to highlight risks for this hospital at a more centralised level.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. The provider had implemented a no smoking policy at the hospital since our April 2019 inspection, but the provider had not formally reviewed the effectiveness of this with staff and patients. During our inspection the hospital manager developed a protocol to stop patients having leave to smoke outside the hospital gate and away from local residents' homes. However, we saw people still smoking there when we visited 20 November 2019. We received feedback that patients were not fully consulted about changes to the policy.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Information management

The provider had some systems to collect data from wards and directorates that were not over-burdensome for frontline staff. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed.

Engagement

The provider's systems for acting on patient and carers feedback to develop the service needed improving. Whilst managers and staff had access to the feedback from patients, there was limited information available about how staff acted to address issues. They were looking to recruit a social worker to help them with this process. Patients and staff could meet with the hospital manager to give feedback.

The hospital manager and other senior staff leaders engaged with external stakeholders – such as commissioners.

Team meeting minutes August 2019 showed staff had requested a designated staff room. The hospital manager had identified a room for this and was seeking funding for transforming into a staff room.

Learning, continuous improvement and innovation

Staff told us they were encouraged to consider opportunities for improvements and innovation. The ward currently did not participate in accreditation schemes relevant to the service.

Requires improvement

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Good
Well-led	Requires improvement

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Whilst staff alarms worked on the ward they did not work across wards and it would not be easy to identify if an urgent response was needed for another ward. The provider had identified this risk on the hospital's risk register. During our visit Oak Court staff reported an incident where a key had gone missing. The provider reminded staff that key pouches should always be used to reduce this risk. However, we identified there were insufficient key pouches for all staff use.

The ward layout allowed staff to observe all parts of ward. The provider's ligature risk assessment identified the removal of ligature points but had not identified clear timeframes for this and we noted wards had different formats. One staff member did not know where the ligature cutters were held, which could pose a risk in an emergency.

The ward complied with guidance on eliminating mixed-sex accommodation as the hospital and these wards was for male patients only.

The ward did not have a seclusion room. Staff understood what the definition of seclusion and when it should be reported.

Staff completed regular risk assessments of the care environment. The provider had taken action following our 2018 inspection to improve Oak and Larch Court ward environments which were clean and tidy.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. However, one oxygen cylinder was beyond the expiry date. This could pose a risk it would not be effective when needed.

Safe staffing

The provider could not demonstrate there were sufficient nursing staff deployed to support patients on each shift. We found inconsistency in recording scheduled staff on shift on duty rotas and the actual staffing record. We reviewed a sample of staffing rotas for the previous six weeks of our visit and found discrepancies in staffing records. On one night shift the rota showed five staff whereas another rota showed 11 staff and documents gave conflicting information about how many staff were on duty. Staff team meeting minutes in July 2019 referred to having insufficient staffing if staff escorted patients in the community. However, the service had enough nursing and medical staff, who knew the patients and received basic training.

Information from the provider showed these wards had eight nurses and 15 support workers. There was one nurse and seven support worker vacancies. Information from the provider between June to November 2019 showed Larch had 12 and Oak had 17 unfilled nursing staff shifts. At night the hospital has a nursing coordinator who worked across wards and was based on Ramsey ward.

The ward manager could adjust staffing levels daily to take account of staff skills and gender mix. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Information from the provider between May to October 2019 showed Oak Court had the highest use of bank and agency staff (as and when required) compared to other wards. Their highest agency

staff usage was 41% in October and their lowest was 13% September (there were four months when over 20%).This was because most patients needed continuous enhanced observations. Oak Court's highest use of bank staff was 14% in September and their lowest was 10% in May and October 2019. Larch Court had the highest percentage of bank staff with 15% usage in September and their lowest was 3% in October 2019. Their highest use of agency staff was 36% in June and their lowest use was 3% in July. Where possible staff tried to use regular staff who knew the patients.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

The ward manager was unable to give us the overall staff percentage for staff sickness or turnover but was able to identify the reasons for staff being on sickness leave or leaving the service.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The wards had a consultant psychiatrist and speciality doctor. Out of usual working hours, doctors were not based on site and staff could contact the on-call speciality doctor and consultant for support.

Most staff had received and were up to date with appropriate mandatory training. Information from the provider showed, overall compliance rates of 92% for Larch and 98% of Oak staff were compliant with mandatory training.

Assessing and managing risk to patients and staff

Staff were not adhering to the provider's policies and procedures for staff observation of patients. Whilst the provider had a system for completing night checks to reduce the risk of them being on observations for more than two hours, we found 10 examples in one week of staff completing more than two hours continuous enhanced observation on Oak Court. This posed a risk that staff may be too tired to effectively observe/support the patient. During review of CCTV footage, we identified a further issue relating to staff not completing enhanced observations of the patient as prescribed or in accordance with the provider's policy. The hospital manager stated they would investigate this further. Additionally, we checked a sample of restraint incidents against closed circuit television images to check on the accuracy of reporting as we had received concerning information with allegations of inappropriate staff restraint of patients for this ward. We found one example where we could not locate the incident footage for the time recoded.

Staff used a nationally recognised risk assessment, the Short-Term Assessment of Risk and Treatability tool.

The ward had a restricted and prohibited items list and search processes. Staff had restricted all patients access to the kitchenette/servery to prevent causing harm to themselves or others with hot water. Whilst there were no apparent delays with accessing the area, this meant patients would have to ask staff for a hot drink or access to make a drink or snack. However, staff risk assessed patients individually for access to their mobile telephones.

Staff used restraint only after attempts at de-escalation had failed. Information from the provider between April and September 2019 showed 237 restraints for all wards. There was no data given for October 2019. Data for 2019 showed 16 restraints on Larch and 170 on Oak. (For 2018, Larch had 145 and Oak 110 restraints).The ward staff participated in the provider's restrictive interventions reduction programme. There were no recorded staff restraints of a patient in prone (face down) position. Staff were clear this should not be used. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Staff used positive behavioural support plans to identify triggers for staff as to when patients might become unsettled.

There were no recorded incidents of staff using seclusion or long-term segregation with patients. Staff attended a twice daily situation-report meeting where any incidents were discussed and any changes in risks to, or posed by, patients were responded to.

Safeguarding

Larch staff had not fully completed a patient's protection plan to give sufficient information for staff about an incident and how to support a patient. Managers took action to investigate an incident of alleged abuse on Oak Court. However, it was unclear how staff were given support during this time and how feedback was given to them following the investigation and outcome. The

provider's policy referred to staff receiving safeguarding supervision. We saw this was a standard supervision agenda item, but we saw limited examples where staff were actively using supervision for discussion of issues.

Staff were trained in safeguarding and knew how to make a safeguarding alert. Staff worked in partnership with other agencies. The hospital had a process for staff to contact the advocacy service following allegations of abuse, so advocates could meet with the patient. However, this did not routinely happen. Staff followed safe procedures for children visiting patients and had identified an area off the ward for visits.

The provider had developed a staff toolkit for 'making safeguarding personal' within the hospital and had developed information folders on wards for staff to reference. These held information such as newsletters including seven-minute briefings for example about self neglect, coercion, the dark web and county lines.

Staff access to essential information

Staff used more than one record system, using a mixture of paper and electronic records. This did not cause them any difficulty in entering or accessing information.

Information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. However, staff told us that they could not easily access records if a patient moved from/to another of the provider's locations and we saw this posed problems for investigators of incidents when they could not gain full access to records to inform their investigation.

Medicines management

We checked all patients' medication records and found staff mostly followed good practice in medicines management (such as, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. The provider had a system for checking nurse's competency.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance. The hospital had a contracted pharmacy service which also had arrangements for gaining medication out of hours, including for pain relief or a cold.

Track record on safety

Information from the provider from April to October 2019, showed 43 serious incidents requiring investigation across wards.

Reporting incidents and learning from when things go wrong

The provider needed to make improvements for incident investigation and to ensure actions were completed. The provider had a system for checking and improving the quality of staff's completion of incident reports, but it did not capture the feedback given to staff nor did it identify any themes and trends for staff learning and development.

We checked a sample of eight incident investigation reports written since May 2019. The provider had developed a quality assurance process to help improve the standard. However, we found the quality of reports still varied with eight needing improvements as they did not always identify risks and actions to reduce the risk of reoccurrence. We found staff used different templates with different layouts and prompts for information. The hospital manager said they had asked for most incidents to be investigated as a serious incident until they could be assured their incident investigation systems were robust. Four reports did not fully identify if the provider had met the duty of candour requirements. Duty of candour is a legal obligation for providers to be open and transparent, and to give patients and families a full explanation if and when things went wrong. From an audit of four incident investigation reports across the hospital one had achieved 100% but one achieved 40% and it was unclear how the provider had used this information to improve future reports. An incident investigation action recommended 'simulation exercises' to take place. After the site visit, the provider sent us an example of these for 18 October 2019.

Wards had 'lesson learnt' folders and staff received emails. Staff supervision and team meetings had learning from incidents as a standard agenda item. However not all staff received regular supervision and examples we saw often held limited information. We checked a sample of staff meeting minutes and saw there was no standard agenda template for Larch Court. There was no reference to lessons learnt following incidents in the last three meeting minutes. Oak Court staff used the corporate agenda template to record their staff meeting minutes. We saw some reference

to lessons learnt in September 2019 following incidents and staff actions. However, the October 2019 meeting minutes did not show these actions were referenced as being completed.

The provider had ensured senior staff had received training in root cause analysis to support them with incident investigations. However, the hospital manager had identified staff needed more bespoke training for incident investigations, which was being sourced.

We saw examples that staff and patients had debriefs after incidents such as restraint. However, we found gaps for four (out of seven) incidents where we could not locate staff or patient debrief forms. It was unclear if this had been considered. Psychology staff were available to support staff after serious incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We checked six patients' records across wards. Staff completed an assessment of the patient in a timely manner at, or soon after, admission. Staff assessed patients' physical health needs.

Staff developed care plans that mostly met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented. Staff updated care plans when necessary.

Best practice in treatment and care

The ward had identified psychology staff who provided low intensity psychology groups suitable for the patient group. They had a therapeutic directory and interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.

Staff ensured that patients had access to physical healthcare, including access to specialists when needed. The hospital was recruiting a new physical healthcare lead. Staff could arrange for patients to see a GP, who visited the hospital twice a week. Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. However, one carer said staff were not effectively supporting patients to manage their weight. Staff supported patients to access a dentist in the community.

Staff used recognised rating scales to assess and record severity and outcomes for example, Health of the Nation Outcome Scales, Liverpool University Neuroleptic Side Effect Scale and National Early Warning Score a tool which improves the detection and response to clinical deterioration in adult patients.

Skilled staff to deliver care

Not all staff had regular line management supervision to ensure they had the skills and knowledge for their role. We had identified this as an area requiring improvement at our 2018 inspection. Latest information from the provider (when we visited) showed 100% of staff had received an annual appraisal and 90% had received supervision across both wards. However, from analysis of the provider's supervision tracker, we identified that 56% of Oak Court staff had supervision (from April to June 2019) and, 72% of staff had supervision (from July to September 2019). Eight staff had no recorded data showing they had received any supervision. Information from the provider showed 67% of Larch Court staff had supervision (from April to June 2019) and 73% of staff had supervision (from July to September 2019). Eleven staff had no recorded data showing they had received any supervision. We sampled staff supervision records and found mostly 'cut and pasted' information so was unclear how the session was individual for the staff member.

We noted in team meeting minutes reference to staff supervision in July 2019 being affected as senior staff were in meetings and not available to supervise staff. A weekly operations report dated 01 November 2109 showed the provider's electronic recording system for staff supervision was inaccurate and not all staff were supervised as indicated. However, the lead psychologist offered weekly reflective practice sessions for ward staff.

The team included or had access to doctors and nurses and psychology staff. The provider had a hospital social worker post advertised.

Managers provided new staff with appropriate induction (using the care certificate standards as the benchmark for healthcare assistants).

Requires improvement

Wards for people with learning disabilities or autism

Doctors and psychology staff said they could access specialist training within the organisation and had arrangements for peer and line management supervision.

Managers ensured that staff received the necessary training for their roles, such as autism and challenging behaviour training.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings.

Staff shared information about patients at effective handover meetings within the team (for example, shift to shift).

The ward team had effective working relationships, including good handovers, with other relevant teams within the organisation (for example, care co-ordinators, community mental health teams, and the crisis team).

The ward team had effective working relationships with teams outside the organisation (for example, local authority social services and GPs).

Adherence to the MHA and the MHA Code of Practice

When we visited on 12 November 2019 Oak Court had eight patients detained under the Mental Health Act 1983/2007 and one informal patient. Larch Court had four patients detained under the Mental Health Act 1983/2007.

Staff did not consistently administer medication to patients under the correct legal authority. We identified four errors on Oak and Larch Court where staff had not correctly completed two patients' prescription charts relating to the 'T2' consent to treatment form and had not correctly completed two patients' prescription chart relating to a 'T3' form where they lacked consent to treatment. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. Administrators had links with other provider locations to gain/give support.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. The provider displayed a notice to tell informal patients that they could leave the ward freely and patients signed a contract agreeing to their admission. The provider had systems in place for staff to request mental health assessments if they had concerns about the patient's capacity to give consent.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The latest 20 September 2019 showed 95% compliance. However, the audit did not check that staff had easy access to the approved mental health practitioner's reports.

Good practice in applying the MCA

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Staff took all practical steps to enable patients to make their own decisions.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies.

Requires improvement

Wards for people with learning disabilities or autism

The service had arrangements to monitor adherence to the Mental Capacity Act. However, an incident had occurred relating to a patient subject to deprivation of liberty safeguarding and staff's oversight and monitoring of this application was not robust. The provider had conducted an investigation and staff learning to reduce the risk of reoccurrence. We saw administrators had a tracker in place to monitor applications and expiry dates.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

We spoke with five patients and four carers across these wards. Four carers expressed concerns that staff were not supporting their relative with their personal hygiene. Whilst we did observe examples where staff proactively supported patients on Oak Court, we also saw on 13 November 2019 some staff passively just observing patients rather than engaging with them. Oak Court staff had not fully protected patient's privacy and dignity as some patients' bedroom doors were open when they were asleep. This meant other patients walking by could see into the room. Oak Court staff gave out certificates to patients for good behaviour, being helpful and for good personal hygiene. We considered that this method was not appropriate for this patient group. The hospital manager stopped this when we brought to their attention.

Patients were positive about the care they received, and carers were mostly satisfied with the care given to their relative. Patients said staff treated them well and behaved appropriately towards them.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Involvement in care

The provider needed to make improvements to how they involved patients and communicated with carers about patients' care. We checked six patients care and treatment records. Staff had not demonstrated in four records how they had involved the patient (although two of them showed carers involvement. Four carers told us that staff did not routinely keep them updated on their relative's care or provide carer's information. Oak Court staff had developed a file giving some information for carers about the service, some language was not always carer centred for example reference was made to 'co morbid presentations' and some data on outcome measures did not have sufficient detail on what was being measured.

Staff used the admission process to inform and orientate patients to the wards and to the service. Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff enabled patients to give feedback on the service they received (for example, via community meetings. Staff ensured that patients could access advocacy.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The average length of stay between November 2018 to October 2019 was 520 days on Larch Court and 300 days for Oak Court. This is below the national average length of stay for patients with a learning disability (554 days Learning Disability Census England 2015).

The majority of patients were not from the local area, with some patients placed over 50 miles away from their homes. We considered this would be difficult for patients to keep in contact with family and friends. Staff, patients and carers gave examples of arrangements to keep in touch with local areas.

The provider had a system assessing patients' suitability for the ward prior to admission. However, staff gave an example where they had admitted a patient in an emergency who was not suitable for the ward. The current

management team supported the team to liaise with commissioners to. The current management team supported the team to liaise with commissioners to discharge patients to appropriate placements.

In comparison with other wards, five of six patients care plans checked did not evidence discharge planning. This is important for patients and carers to plan for the future. There was one patient with a delayed transfer (which was beyond the provider's influence). We saw examples where staff, in liaison with commissioners had referred patients to low secure units if a patient required more intensive care.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms which they could personalise. Patients had a secure place to store personal possessions and patients could lock their bedrooms. Staff used a full range of rooms and equipment to support treatment and care. This included a sensory room. Staff supported patients through individual and group cooking sessions and provided an independent living skills group at the Joy Clare centre.

There were quiet areas on the ward and a room where patients could meet visitors. Patients could make a phone call in private. Patients had access to outside space. Three Oak and Larch Court patients told us they liked the food.

Patients' engagement with the wider community

The Joy Clare centre had a recovery college with an established programme of sessions to support patients with their access to educational courses and working opportunities. The programme was not fully operational at the time of the inspection but would recommence once all recently recruited occupational therapy assistants were in post. Patients were still able to complete curriculum vitae and were supported to look for volunteering and job opportunities. Patients could access and use computers to maintain contact with the wider community and families. However, the Joy Clare Centre was not on the hospital site and was only accessible to patients prescribed section 17 community leave. Patients without prescribed leave accessed ward based activities.

As relevant, staff supported patients with local community leave. for example staff took patient to on a seal watching trip. When appropriate, staff ensured that patients had access to education and work opportunities. Staff supported patients as relevant to understand their right to vote in a general election.

Meeting the needs of all people who use the service

The service made adjustments for disabled people – for example, by ensuring access to premises and by meeting patients' specific communication needs.

Some staff had specialist Makaton skills to communicate with patients. The provider had displayed patient information using 'widget symbols' such as to help patients identify pain, mood and wellbeing where patients were supported to describe how they were feeling. We saw some visual care plans. However, whilst the provider had a range of tools they used to help communicate with patients, the provider had not completed a specific assessment of how they were meeting the accessible information standards to meet patients' needs. There is a requirement of all providers of NHS care and publicly-funded adult social care to follow the Accessible Information Standard in full of 1 August 2016 onwards - in line with section 250 of the Health and Social Care Act 2012.

We saw staff considered patients' protected characteristics in line with The Equality Act 2010, such as age; disability; race; religion or belief and sex. Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. The provider had a multi-faith room. Patients could request spiritual support and staff tried to support patients to access local faith groups but were still developing contacts for this.

Listening to and learning from concerns and complaints

Improvements were needed to demonstrate managers were sharing learning and feedback following complaints to improve the service. Information was limited about how the provider had responded to these complaints before April 2019. The hospital had received 20 complaints since January 2019 with 12 relating to issues with 'therapeutic intervention'. Information from the provider showed the hospital had received 10 compliments from May 2019.

Patients knew how to complain or raise concerns. 'You said we did' boards were seen but were not completed.

Requires improvement

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Leadership

Whilst the provider had made notable changes to improve and strengthen the leadership of the hospital in the last 12 months and since our last April 2019 inspection. The provider had not fully addressed risks from our 2018 and 2019 inspections.

The ward manager was newly employed and had experience of working with this patient group. In addition to the hospital manager in post since April 2019, the provider had newly employed a clinical service manager with relevant experience to help the leadership team. The Operations Director who started working with this hospital in January 2019 worked across several hospital and locations visited weekly and was accessible. A new interim medical director started November 2019. The majority of staff told us the management structure of the hospital was much improved and they felt more confident in their ability to lead and improve the hospital. The hospital manager said they additionally received leadership support from the provider's corporate central team such as the head of clinical risk who was on site when we visited 20 November 2019. Additionally, other senior staff such as the managing director and director of nursing had visited. However, most ward staff were not aware of other leaders visiting to support the hospital. We had concerns that the provider had not given the hospital manager sufficient support and resources to implement the required changes in a timely manner.

Vision and strategy

Staff knew the provider's vision and values. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Wards had identified 'values' champions.

Culture

Staff meeting minutes from Larch Court for July 2019 identified there was a lack of senior staff available for staff to raise concerns. Staff meeting minutes from October 2019 referred to staff not receiving feedback for issues raised in supervision. Senior managers had an awareness of the need to ensure closed cultures did not develop on the ward and within the hospital. Following feedback from staff they were planning to make changes to Oak and Ramsey ward teams. Managers carried out night spot checks of staff competency. The average staff sickness rate from May to October 2019 for Oak Court ranged from the highest in October at10% to the lowest in May at 1%. Larch Court highest sickness rate was 7% in July and the lowest rate was 1% in August and September. At times ward sickness rates varied between being above and below the national NHS staff average (4.2% for 2016/2017). Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service – for example, through staff awards and an Oak ward staff member had recently won an award under the provider's value of 'respect'. We asked the provider how the hospital was meeting workforce race equality standards with staff. The provider gave us information about their analysis of data and feedback from their staff survey relating to workforce race equality standards for 2018. The provider's action plan was not specific, measurable, attainable, relevant, and time-based.

Governance

The provider had not fully addressed risks identified from our 2018 and 2019 inspections for example, such as improving staff supervision, to ensure sufficient incident investigations, ensuring a system to share learning or actions with staff and developing their quality assurance system to ensure actions were completed. Additionally, we found improvements were needed to ensure that audit action plans such as for ligature assessment had identified timeframes for completion and oversight of this; that there was an effective system to monitor staff on duty and sufficient activities for patients.

Whilst the provider had a framework of what must be discussed at a ward, team or directorate level in team meetings for essential information, such as learning from incidents and complaints, to be shared and discussed, the system was not as yet fully embedded. We checked a sample of staff meeting minutes. There was not a standard agenda template across wards. There was no evidence of discussing lessons learnt following incidents in the last three Larch Court team meeting minutes.

Until recently the hospital manager did not have a robust management team in place to support them to develop governance system effectively and manage risks in the

hospital. A number of administration team had left employment. The hospital manager now employed a governance assistant and other staff to help them with implementing processes and was in the process of advertising for quality assurance staff posts. Governance meetings now included ward/team meetings, patient safety, senior management, quality and compliance and health and safety groups.

The hospital manager had developed some other ways to help communicate key information to staff such as through monthly staff and safeguarding newsletters. The provider had taken action since our April 2019 inspection, to ensure sufficient staff to meet patient's needs; that staff received essential training (including restraint) and that agency staff had checks before working at the hospital.

Management of risk, issues and performance

The provider's processes for communicating information, including risks, between the hospital and the board were not robust. The hospital manager gave verbal and written reports to the operational director each week, but examples seen did not fully capture issues, nor did the hospital and operational risk register (for example relating to the hospital staff alarm system). This posed a risk that the provider's board would not have sufficient oversight of risks or understanding of the level of support the hospital required to implement changes. The hospital manager addressed this during our inspection.

We saw that seven items were raised in the hospital's senior management meeting July 2019 but were not discussed further in subsequent meetings despite six of them being ongoing concerns and four rated as high-risk issues. There was limited evidence demonstrating the meetings oversight of this to ensure completion and if the risk had increased/decreased. We managed to track actions for these items but not all had been resolved.

The provider had employed a staffing coordinator since October 2019 who had a lead for ensuring essential checks of bank and agency staff were completed before working on the wards. We found examples of staff details not being updated such as to check professional registration details. However, staff were able to check on this and give assurance there were no identified risks. The corporate provider team centrally approved the agencies the hospital could contact, and we understood they assessed and monitored the provision.

The operations director attended a monthly regional clinical meeting to highlight risks for this hospital at a more centralised level.

The provider had implemented a no smoking policy at the hospital since our April 2019 inspection, but the provider had not formally reviewed the effectiveness of this with staff and patients. During our inspection the hospital manager developed a protocol to stop patients having leave to smoke outside the hospital gate and away from local residents' homes. However, we saw people still smoking there when we visited 20 November 2019. Also we were given feedback that patients were not fully consulted about this.

Information management

The provider had some systems to collect data from wards and directorates that were not over-burdensome for frontline staff. However, the ward manager did not have easy access to information to support them with their management role, such as training, staff sickness and turnover data.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed.

Engagement

The provider's systems for acting on patient and carers feedback to develop the service needed improving. Whilst managers and staff had access to the feedback from patients, there was limited information available about how staff acted to address issues. Wards had patients' community meetings, but governance meeting minutes did not clearly reference feedback from these and it was unclear how actions would be taken forward or reviewed. They were looking to recruit a social worker to help them with this process. Patients and staff could meet with the hospital manager to give feedback.

Patients and staff could meet with the hospital manager to give feedback. The hospital manager and other senior staff leaders engaged with external stakeholders – such as commissioners.

Requires improvement

Wards for people with learning disabilities or autism

Team meeting minutes in August 2019 showed managers had identified a staff room for staff to use and were seeking funding for transforming it into a staff room.

Learning, continuous improvement and innovation

Staff told us they were encouraged to consider opportunities for improvements and innovation. The wards currently did not participate in accreditation schemes relevant to the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff complete incident forms appropriately.
- The provider must ensure there are effective processes in place to review patient restraint incidents.
- The provider must ensure staff treat patients with dignity and respect.
- The provider must ensure staff follow patients' management plans to ensure the safety of patients' and staff.

This is a breach of Regulation 13 (1)(2)(3)(4)(7) Safeguarding service users from abuse and improper treatment.

- The provider must ensure staff document their risk assessment of patients before they have community leave.
- The provider must ensure that staff follow the provider's observation policy.
- The provider must ensure ligature risk assessments are comprehensive with timeframes for actions and identify when actions are completed.
- The provider must have an effective staff alarm system.
- The provider must ensure they are prescribing medication in line with Mental Health Act consent to treatment documentation.

This is a breach of Regulation 12 (1) (2) (a)(b)(g) Safe Care and Treatment.

- The provider must ensure adequate governance systems are in place to monitor, assess, manage and mitigate risks and act in a timely manner to address issues of concern for patient safety and ensure actions are addressed from inspections.
- The provider must ensure staff complete incident forms appropriately.
- The provider must improve the quality of incident investigation reports.
- The provider must have a robust system to share all learning from incident investigations and actions with staff.
- The provider must have an adequate system to ensure incident investigation report actions are completed.
- The provider must ensure staff receive regular supervision for their work.
- The provider must ensure leadership and oversight on Ramsey ward.
- The provider must document their involvement of patients in their care plans and discharge plans.

This is a breach of Regulation 17 (1) (2) (a)(b)(c) (d) (ii)(e)(f) Good Governance.

- The provider must ensure they adhere to the duty of candour.

This is a breach of Regulation 20 (1)(2)(3)(4)(5)(6)(7) Duty of candour.

- The provider must ensure Highwoods patients have regular access to activities.

This is a breach of Regulation 9 (1) (a) (b) (c)(2) (3) (b) Person centred care.

Action the provider SHOULD take to improve

- The provider should ensure they have an effective system to communicating risk information between the hospital and board.
- The provider should ensure the registered manager has sufficient leadership support to implement and make improvements to the quality of the service.
- The provider should ensure investigators can easily access archived patients records for their incident investigation.
- The provider should have an accurate system for recording staff on shift.
- The provider should review and address the staff sickness levels on Ramsey ward.
- The provider should ensure the full psychological programme is running on Ramsey ward.
- The provider should ensure Highwoods staff receive personality disorder training.
- The provider should ensure Highwoods staff receive regular supervision.
- The provider should review their implementation of the smoking policy at the hospital.
- The provider should have a system to communicate with carers and engage them in the development of the service.

Outstanding practice and areas for improvement

- The provider should ensure mental capacity assessments are recorded and stored appropriately.
- The provider should ensure staff effectively use the daily risk assessment.
- The provider should review patients access to make drinks and snacks.
- The provider should ensure staff know how to access keys to be able to open and lock windows on Ramsey ward.
- The provider should make some improvements to Highwoods ward environment for staff offices, property storage and the assisted bathroom.
- The provider should complete a specific assessment of how they are meeting the accessible information standards to meet patients' needs, in line with section 250 of the Health and Social Care Act 2012.
- The provider should ensure their action plan for the Workforce Race Equality Standard is specific, measurable, attainable, relevant, and time-based.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment