Cygnet Health Care Limited

Cygnet Hospital Bierley

Inspection report

Bierley Lane
Bierley
Bradford
BD4 6AD
Tel: 01274686767
www.cygnethealth.co.uk

Date of inspection visit: 7, 8, 9 and 10 November 2022
Date of publication: 10/01/2023

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this service stayed the same. This inspection covered the forensic core service only as the other 2 wards were closed at the time we inspected. As the acute and personality disorder core services were not re-rated the overall rating for the hospital remains inadequate, despite the improvements noted in the forensic core service as outlined below.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	Our rating of this core service improved. We rated it as requires improvement because: • Since our last inspection there had been several incidents on one ward where staff may have deliberately abused patients, this was under investigation at the time of our inspection and the provider had suspended all staff involved. • Patients did not always receive adequate support following incidents of self-harm to prevent a similar incident recurring. • Staff had not always received timely emergency life support training updates at a level appropriate to their role. • We identified some instances where patients were subject to restrictions which were not justified on the basis of risk or the hospital had taken insufficient action to review risks leading to the imposition of restrictions. • We identified some isolated areas of the ward environment which were not clean or safe and staff were not always up to date with training to support them in caring for people safely. • Some patients had a named nurse who was on long term leave from the hospital and so did not have regular access to one to one support from a member of ward based staff. • People's views about their care had not always been sought and/or documented in their care records. • Agency staff working at the hospital had not always received an induction specific to the ward they were working on. • Some staff raised concerns about experiencing racial discrimination at work and we did not see evidence that the provider had taken sufficient action to promote equality, diversity and inclusion at the hospital. However: • Staff developed holistic, recovery-oriented care plans informed by a comprehensive

Summary of findings

			assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. • The service was well managed and the governance processes usually ensured that ward procedures ran smoothly.
Acute wards for adults of working age and psychiatric intensive care units	**Inadequate**		As the psychiatric intensive care unit was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.
Personality disorder services	**Inadequate**		As the personality disorder service was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is an independent mental health hospital provided by Cygnet Health Care Ltd situated in West Yorkshire. The hospital is registered to provide care for up to 56 male and female patients across 4 different inpatient wards, 2 of which were open at the time we inspected:

- Bronte ward is a 12-bed forensic low secure service for women
- Shelley ward is a 16-bed forensic low secure service for men

The hospital's other 2 wards were closed following our last inspection and remained closed during and following this inspection. The provider told us they plan to re-open these wards as acute wards for adults of working age in early 2023.

The hospital has been registered with the Care Quality Commission since October 2010 to carry out the following regulated activities:

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

• Treatment of disease, disorder or injury

At the time we inspected the hospital had an accountable controlled drugs officer but there had been no registered manager in post since June 2022. A hospital manager had been in post since 1 November 2022 and told us they were planning to apply for CQC registration.

The Care Quality Commission last carried out a comprehensive inspection of this hospital in February 2022. As a result of that inspection, we rated the service as inadequate overall and placed the service in special measures. The forensic services were rated inadequate overall with safe and well led domains rated inadequate and effective and caring domains requiring improvement. The responsive domain was not rated at this inspection.

The hospital was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last inspection:

- Regulation 9 Person centred care
- Regulation 10 Dignity and respect
- Regulation 12 Safe care and treatment
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 17 Good governance
- Regulation 18 Staffing

This was a comprehensive inspection to assess whether the provider had made improvements to meet the requirement notices we issued in relation to the above breaches. At this inspection we inspected all five key questions on both of the wards which remained open at the time we inspected.

What people who use the service say

We spoke with 9 people who were using the service. The people we spoke with were mostly happy with their care at the hospital. People on both wards all told us that staff treated them with respect and kindness. They said the food was

Summary of this inspection

good and they were able to take part in activities they enjoyed both on and off the ward, although some people said they could not always have leave when they wanted due to shortages of suitable staff to escort them. People on Shelley ward said they would like to be able to access the computer more frequently. Many patients were placed at the hospital away from their local areas so their relatives could not easily visit but people told us they were able to stay in touch with their families and friends by phone. People said they felt safe at the hospital and they did not have excessive restrictions imposed on them. Some people told us that they felt like staff did not give them enough privacy and some complained about how medication was given to them. Some people said they did not have a clear plan for the steps they needed to take in order to be discharged from hospital. Several people on Shelley ward said they did not have a key to their own bedroom and they would like to have one.

We were not able to get any direct feedback from relatives/carers to inform this inspection.

How we carried out this inspection

The inspection team comprised 2 CQC inspectors, a mental health nurse specialist advisor and one expert by experience.

During the inspection, the inspection team:

- visited both forensic wards
- spoke with 9 patients who were using the service
- spoke with the hospital manager and 2 consultant psychiatrists who were the responsible clinicians for both wards
- spoke with 2 ward managers
- spoke with 14 staff members including nurses, support workers, activity coordinators, allied health professionals and housekeepers
- reviewed the prescription charts and care records for all patients
- spoke with 2 independent advocates
- received feedback from 3 external agencies
- attended a range of meetings including ward handovers, multi-disciplinary team meetings, ward rounds, ward community meetings, a people's council and governance meetings
- looked at a range of policies, procedures, and other documents relating to the running of the service.

Visits were unannounced and took place on the evening of 7 November 2022 and during the day on 8, 9 and 10 November 2022.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that all patients have access to regular one to one support from a named nurse who is not on long term absence from the hospital. (Regulation 9 (1) (b))
- The service must ensure that a consistent approach is taken to the management of ligature risks on both wards to meet the needs of the patients. (Regulation 12 (2) (b))
- The service must ensure that individuals have their care plans reviewed following incidents of self-harm to ensure they are provided with care and support to mitigate the risk of a similar incident recurring as far as reasonably practicable. (Regulation 12 (2) (b))
- The service must ensure that all areas of the hospital are kept clean and records are maintained to provide assurance that cleaning is taking place. (Regulation 12 (2) (d))
- The service must ensure that all staff receive regularly updated training on emergency life support at a level appropriate for their role. (Regulation 12 (2) (c))
- The service must ensure that patients are protected from any further abuse by staff, that investigations continue in conjunction with local police and safeguarding teams in relation to the allegations of patient abuse on Shelley ward and that action is taken in relation to any substantiated concerns about abuse to hold the perpetrators to account and prevent a recurrence. (Regulation 13 (1) and (3))
- The service must ensure that patients do not have their right to section 17 leave from the hospital restricted more than is necessary on the basis of risk. (Regulation 13 (5))
- The service must ensure that patients can have a key to their bedroom unless this is not appropriate on the basis of individually assessed risk. (Regulation 13 (5))
- The service must ensure that all bank and agency staff receive a ward-specific induction prior to commencing work on any ward at the hospital. (Regulation 18 (2) (a))
- The service must ensure that staff do not experience discrimination on the grounds of any protected characteristics and that action is taken in relation to the ongoing concerns raised by staff about experiencing racial discrimination at work. (Regulation 18 (2) (a))

Action the service SHOULD take to improve:

- The service should ensure that staff are reminded of their obligations to comply with all infection prevention and control measures applicable to their role including standards of dress while in patient areas.
- The service should review the blanket restrictions in relation to locked activity rooms and access to outside space on both wards to ensure they are only in place if required on the basis of risk.
- The service should ensure that staffing establishment levels and skill mix for each ward reflect the needs of the patients.
- The service should ensure that handover meetings take place when staff responsible for security checks are able to attend without having to work additional hours.
- The service should continue to take action to reduce the high staff turnover rate at the hospital, identifying the reasons for staff leaving wherever possible and addressing any trends of concern which arise from this data.
- The service should ensure that the requirements for male staff members to be involved in leave and/or observations on Shelley ward are reviewed for all patients affected by this to ensure this is only in place where necessary and that Shelley ward is staffed so that patients are not prevented from taking escorted leave due to the risks associated with female staff escorting them.
- The service should ensure they continue to monitor the effectiveness of staff safeguarding training on all wards.
- The service should ensure all staff receive regular training updates on the prevention and management of violence and aggression.
- The service should ensure that staff on Bronte ward complete medication fridge temperature checks at the required internals.
- The service should ensure regular clinical supervision is available for all staff groups.

Summary of this inspection

- The service should ensure that when audits are carried out these are sufficiently comprehensive to produce meaningful data and are followed by the implementation of SMART action plans to address any identified issues.
- The service should ensure all patients have an opportunity to contribute to their care plans and their views are documented within the plans.
- The service should ensure that any patients who wish to have contact with family or friends from their local area through video conferencing are supported to do so regularly.
- The service should consider if any action should be taken in relation to the average length of stay on both wards in comparison with the national average for forensic/secure inpatient services.
- The service should consider whether written information about the complaints process should be included in the welcome pack provided to new patients on both wards.
- The service should consider how information about changes to patients' discharge plans could be shared more pro-actively with external stakeholders.
- The service should consider improving the documentation of post-incident de-briefs to provide assurance that staff are being supported following incidents as needed.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate
Personality disorder services	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Requires Improvement

Forensic inpatient or secure wards

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Safe and clean care environments

The wards were well equipped, well maintained and fit for purpose but were not always clean, safe or well furnished. Ligature risks were not always managed consistently.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. A range of environmental risk assessments including ligature, fire and infection prevention and control risks had been carried out and recently updated in relation to both wards.

Staff could observe patients in all parts of the wards. Both wards were a T-shape with the nursing station situated where staff could observe all the way down both corridors. We saw that staff spent the majority of their time on the ward with patients and there were CCTV cameras in areas which were out of direct sight of the nursing station, such as the seclusion suite.

The ward complied with guidance and there was no mixed sex accommodation. Both wards were single sex, one for men and one for women.

Staff knew about any potential ligature anchor points but did not always sufficient mitigate the risks to keep patients safe. We observed unboxed cables which presented a potential ligature risk on both wards. These had been identified on the wards' ligature risk assessments but on Bronte ward one of the mitigating factors in the risk assessment (last reviewed 9 November 2022) was that the room was kept locked and this was not the case in practice. On Shelley ward the ligature risk assessment stated that staff should pack away the cables (for the games console in the chill out lounge) when not in use but we observed cables in this room which had not been packed away, showing again a lack of consistency between the documented risk assessment and the practice followed on the ward. Staff on both wards were aware of the risks and stated that there was no one on the ward who was at risk of self-harming by ligature at the time we inspected. However, this still could potentially lead to avoidable harm to patients if people's needs changed or new patients were admitted. The ward manager on Bronte ward confirmed a request had been made to the facilities team for the TV to be boxed in as soon as possible.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff had personal alarms and the staff we spoke with told us that their colleagues were able to attend quickly when alarms were pulled. Patients all had a nurse call button in their bedroom and there were also call buttons in each communal room.

Maintenance, cleanliness and infection control

Ward areas were fit for purpose and mostly clean and well maintained but were not always well furnished. We observed chairs in communal areas on both wards which had ripped fabric and a patient on Shelley ward told us that the furniture had been changed recently and it had been better before. The end of the servery counter on Bronte ward was visibly dirty. Some patients on Shelley ward said the ward was not always clean. However, other than the isolated issue on Bronte ward, both wards appeared clean at all times during our inspection and we saw cleaning taking place on both wards both during day and night shifts.

Staff did not always make sure cleaning records were up-to-date. We reviewed the night cleaning records for both wards which were up to date and complete other than the occasional missing signature. We also asked for housekeeping records to be shared from both wards for the 4 week prior to our inspection (10 October to 4 November 2022), a period of 28 days. Only 21 days of records were provided in relation to Shelley ward and only 6 days of records were provided in relation to Bronte ward.

Staff did not always follow the provider's infection control policy. The policy stated that staff should be bare below the elbows while on the wards and we observed a number of staff members wearing long sleeves and/or wrist watches while on the ward. The provider had identified this as an issue as it was discussed in the governance meeting we observed and the ward managers were asked to remain all staff on their wards of the bare below the elbows policy.

Seclusion room

The seclusion room on Shelley ward allowed clear observation and two-way communication. It had an en suite toilet and a visible clock and calendar. Bronte ward did not have a seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The records of the emergency drugs checks and the medicines fridge temperature checks were up to date and complete with the exception of 1 missed check on Bronte ward. The defibrillators on both wards were last serviced in February 2022.

Staff usually checked, maintained, and cleaned equipment. Equipment in both clinic rooms was well organised, in good condition and marked with "I am clean" stickers in accordance with the provider's policy. However, the emergency bag on Bronte ward was still ripped on one side which was something we fed back to staff at our previous inspection. All the hospital's clinic equipment was serviced and calibrated by an external provider in February 2022.

Safe staffing

The service usually had enough nursing and medical staff, who knew the patients. However, not all staff had received sufficient basic training to keep people safe from avoidable harm.

Nursing staff

The service usually had enough nursing and support staff to keep patients safe. Weekly rotas were prepared and where the number of permanent staff on a shift fell below the establishment level this was identified and action was taken to request support from bank or agency workers. Both wards were fully staffed throughout our inspection including when we visited unannounced at night. However, the skill mix did not always reflect the provider's recommended levels as

both wards should have had 2 nurses on both day and night shifts and this was not always the case, including the evening we visited when there was only 1 nurse on the night shift. The provider monitored staffing levels and their data showed that there was 1 nurse less than establishment on 6 occasions on Shelley ward and 7 occasions on Bronte ward in the 6 months preceding our inspection. On each occasion there was either an additional support worker working to ensure staffing numbers were at the required level or senior nursing staff and/or staff from other wards provided additional support.

The service had low vacancy rates. At the time of our inspection there was only 1 vacant post (a ward manager for one of the closed wards) at the hospital.

The service had low rates of bank and agency nurses and support workers. Most of the staff working on both wards during our inspection on both day and night shifts were permanent staff members. The provider monitored bank and agency usage on both wards. Between 1 May 2022 and 13 November 2022 there were no agency nurse hours on either ward, 5% of staff hours were completed by agency support workers on Bronte ward and 2% on Shelley ward. For the same period 1% of hours were completed by bank nurses and 4% of hours were completed by bank support workers on Bronte ward and 2% of hours were completed by bank nurses and 2% of courses were completed by bank support workers on Shelley ward.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Patients told us that when agency staff worked on the ward they were usually people they knew.

Managers did not always make sure bank and agency staff had a full induction and understood the service before starting their shift. The provider used an online system for booking bank and agency shifts and staff who were out of date with mandatory training were flagged on the system. A spreadsheet was also meant to be held on each ward and on reception which recorded which staff members had undertaken ward and security inductions for each ward. However, the printed version of the spreadsheet on Shelley ward was dated 17 October and there was no spreadsheet available on Bronte ward. Staff said if they were not sure if an agency worker had undertaken the hospital's induction they would call the hospital's receptionist and ask them to check their spreadsheet. Summary profiles were available for the last 5 members of agency staff who worked on both wards which showed their mandatory training compliance in addition to recruitment information such as their DBS check and Nursing and Midwifery Council registration where relevant. Induction records were also available for these members of staff but 3 of the 5 workers on both wards had received their induction on a different ward and we saw no evidence they had received a ward-specific induction for the ward they had most recently worked on at the hospital.

The service had high turnover rates. The average monthly percentage for staff turnover in the period November 2021 to October 2022 was 34%. The average for nurses was 20% and for support workers it was 33%. The provider was carrying out exit interviews and sending survey links to leavers where possible to try to identify any trends and take action to improve staff retention.

Managers supported staff who needed time off for ill health. Staff told us they were able to take time off if they were sick and were well supported when returning to work after sickness absence.

Levels of sickness were low and reducing. At the time we inspected there were 5 out of 117 members of permanent staff on long term sick leave. The overall sickness rate across the hospital had reduced from 16% in June 2022 to 9% in October 2022.

Requires Improvement

Forensic inpatient or secure wards

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward managers calculated the staffing levels for their ward and kept these under regular review. We observed a rota meeting at which staffing for both wards over the coming weeks was reviewed and also at the morning governance meeting
(which took place Monday to Friday) ward managers had the opportunity to raise any staffing issues they were facing in the near future.

The ward manager could adjust staffing levels according to the needs of the patients. Staffing levels on each ward were reviewed at the morning governance meeting to identify if they were sufficient to meet patients' needs, for example if any patient needed enhanced observations. The ward managers of both wards said they were able to request additional staff when needed.

Patients did not always have regular one to one sessions with their named nurse. A number of staff members were suspended at the time we inspected, following a serious incident. Some of these staff members were named nurses for patients and no alternative named nurse had been identified for these patients. Some patients told us they were not having regular one to one sessions with anyone on their ward.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Most patients told us that they were able to access activities and escorted leave, however some patients and staff on Shelley ward told us that it was not always possible to facilitate all the escorted leave patients had been granted due to the requirement for some patients to have a male escort and/or for a male staff member to remain present on the ward. We reviewed the leave records for all patients who were granted section 17 leave and we saw that people were regularly accessing leave to the hospital grounds, the local area and sometimes further afield, including family visits.

The service had enough staff on each shift to carry out any physical interventions safely. Staff and most patients told us that physical interventions did not happen frequently on the ward and when they did there were sufficient staff to manage them safely. On Bronte ward 83% of staff were up to date with their prevention and management of violence and aggression (PMVA) training and 100% of doctors and occupational therapists at the hospital were also up to date with PMVA training. However, on Shelley ward only 75% of staff were up to date with PMVA training and 75% of psychologists and 67% of social workers were up to date with this training. One patient raised concerns about how they had been treated when their medication had been forcibly administered.

Staff shared key information to keep patients safe when handing over their care to others. We observed handover meetings on both wards. The handovers were structured around a summary document which listed the key risks for each patient and the nurse on the commencing shift took notes. However on Bronte ward 1 support worker missed the handover because they were undertaking security checks. Another support worker on Shelley ward told us that they had to come in early to do the security checks so as not to miss handover.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Each ward had a dedicated consultant psychiatrist and staff on both wards told us that they could access a doctor quickly when they needed to, including out of hours.

Managers could call locums when they needed additional medical cover. However, this was rarely needed due to stable medical staffing being in place for both wards.

Requires Improvement

Forensic inpatient or secure wards

Mandatory training

Staff had not always completed and kept up-to-date with their mandatory training. On Bronte ward all mandatory training modules had been completed within the provider's timescales by 80% of staff or more. Doctors and occupational therapists were 100% up to date with their mandatory training. However, on Shelley ward only 75% of eligible staff were up to date with their intermediate life support training and 78% were up to date with their PMVA training. Psychologists and social workers were 75% and 67% up to date with their PMVA training, although they were 100% up to date with all the other mandatory training modules.

The mandatory training programme was sufficiently comprehensive to meet the needs of patients and staff. This included a range of modules relevant to patients' care including safeguarding, prevention and management of violence and aggression, management of medication, infection prevention and control and emergency life support at basic and intermediate levels.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they received reminders when their mandatory training updates were due and we saw how training compliance was monitored by ward managers and through governance meetings.

Assessing and managing risk to patients and staff

Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, staff did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always assess and manage risks to patients and themselves well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All the records we reviewed contained a completed and up to date risk assessment using the Short Term Assessment of Risk Tool (START) which is a recognised tool. The risk assessments we reviewed had been updated when patients' risks changed, for example following incidents.

Management of patient risk

Staff usually knew about any risks to each patient and acted to prevent or reduce risks. The risks relating to each patients' care were systematically reviewed at the handover meetings we observed and the records of handovers showed these were taking space at each change of shift. A register of blanket restrictions was kept and a list of blanket restrictions was displayed on both wards. The blanket restrictions were being regularly reviewed to make sure they were still required to keep people safe, however it was not always clear that these were removed where no longer necessary. On Shelley ward the activity room was kept locked when not in use and the ward manager stated that this was because the sink taps presented a ligature risk, however they also said that none of the patients on the ward at the time of the inspection were at risk of self-harm by ligature. There were blanket restrictions on both wards in relation to access to the courtyard which was locked and patients could only access with support from staff, which again staff said was justified on the basis of ligature risks.

Staff usually identified and responded to any changes in risks to, or posed by, patients. A daily risk meeting was held by the multi-disciplinary team on each ward every weekday morning where any change to each patients' presentation and any incidents they had been involved in were reviewed and any required changes to their plan of care were agreed and documented on their records. However, we identified concerns in relation to the care of 1 patient where repeated

incidents of self-harm occurred due to swallowing inedible items. Following the first incident the patient's risk assessment was reviewed but they retained unsupervised access to items they were known to attempt to swallow and further instances of swallowing took place. The same patient was also involved in a serious choking incident due to attempting to ingest an inedible item. They did not receive any psychological interventions in relation to their self-harming behaviour between the date of the first swallowing incident and our inspection.

Staff could observe patients in all areas of the wards. There were CCTV cameras in rooms which were out of the direct line of sight of the nursing station where patients could have unsupervised access.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff and patients told us that searches only took place as required by individual risks rather than as a blanket restriction.

Use of restrictive interventions

Levels of restrictive interventions were low on Shelley ward. In the 12 months preceding our inspection there had been 30 recorded restraints on the ward involving 3 patients. On Bronte ward the recorded restraints were high at 835 in the 12 months preceding our inspection. However, of these, 749 were twice daily planned restraints which had been required by one patient's plan of care. At the time of our inspection this planned restraint was no longer necessary so levels of restraint on Bronte ward had significantly reduced. The remaining 86 restraints on Bronte ward involved 4 other patients over the 12 months preceding our inspection, one of whom had been restrained 47 times. The patients and staff we spoke with on both wards told us that unplanned restraint and seclusion rarely happened on the wards.

Levels of restraint in the prone position were low on both wards (3 occasions on Bronte ward and 1 occasion on Shelley ward in the 12 months preceding our inspection). There had been some isolated occasions where patients had complained about excessive force or inappropriate techniques being used during restraint. The provider had investigated these concerns and had taken appropriate action.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Eighteen cohorts of staff from the hospital attended Cygnet's training course on reducing restrictive practice between April and November 2022. There was no representative from the hospital at the regional meeting of Cygnet's Positive and Safe delivery board in July 2022 and data on restraints at the hospital was not submitted to board for review at the meeting. However, the interim hospital manager attended this meeting in October 2022 and the data was submitted as required.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients had a positive behaviour support plan which included details of how each individual should be supported to prevent the need for restrictive interventions. Records showed staff were usually working to these plans and most patients confirmed that they were rarely or never physically restrained.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Due to the nature of the service there were no informal patients on the wards.

Staff followed NICE guidance when using rapid tranquilisation. Records showed that people had physical health observations and a medical review following rapid tranquillisation in line with NICE guidance. Rapid tranquillisation use was low on both wards (4 instances on Bronte ward and 1 instance on Shelley ward in the 12 months preceding our inspection).

Requires Improvement

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There had been no seclusions involving patients from the secure wards since our last inspection and only 2 involving 1 patient from Bronte ward in the 12 months preceding our inspection.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. No patients had been put into long-term segregation at the hospital since our last inspection.

Safeguarding

Staff had training on how to recognise and report abuse but they did not always demonstrate that they knew how to apply it in practice. However, the service worked well with other agencies to protect people from abuse when concerns were identified.

Staff received training on how to recognise and report abuse, appropriate for their role. Over 97% of staff from all staff groups across the hospital were up to date with their safeguarding training which was at a level appropriate to their role.

Staff were kept up-to-date with their safeguarding training. However, since our last inspection there had been a number of safeguarding concerns raised in relation to staff behaving abusively towards patients on Shelley ward in October 2022, which were identified through the provider's regime of CCTV spot checks. These incidents had been observed by other staff on the ward without any action being taken or safeguarding concerns raised. The provider responded appropriately to these concerns and all staff who had participated in and/or observed these incidents had been suspended. A further incident of inappropriate staff behaviour towards a patient on Shelley ward occurred later in October 2022, again the staff member was suspended and appropriate action was ongoing by the provider to investigate. In addition, a wider cultural review had taken place at the hospital which included values-based interviews with staff to provide additional assurance that the remaining staff understood what would constitute abuse of a patient and what action they should take in response to concerns about abuse.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The staff we spoke with were aware of how to support people with protected characteristics to ensure they receive care on an equal basis to others, for example by arranging interpreters for people whose first language was not English and providing easy read information for people who required it.

Staff did not always demonstrate they knew how to recognise adults and children at risk of or suffering harm and work with other agencies to protect them. Since our last inspection there had been concerns about abuse of patients by staff on Shelley ward. The events leading to these concerns were witnessed by staff who did not take action to report any safeguarding concerns. In the March 2022 regional safeguarding meeting it was noted that ward staff were not always sharing information about safeguarding concerns appropriately. However, as noted above action had been taken by the provider in the months immediately preceding our inspection to ensure that staff had a clear understanding of what would constitute a safeguarding concern and their responsibility to report concerns as soon as possible on witnessing anything potentially abusive.

Staff followed clear procedures to keep children visiting the ward safe. There was a visiting room off the main ward where patients could meet with any children who were able to visit them. This was risk assessed on an individual basis.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the staff we spoke with were aware of how to report a safeguarding concern and there were flowcharts displayed in the ward offices detailing the reporting procedure.

Requires Improvement

Forensic inpatient or secure wards

There had been no serious case reviews relating to patients at the hospital in the 12 months prior to our inspection.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All staff could access the records of the patients they worked with.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. All the electronic and paper records we reviewed were up to date and cross-referenced so staff knew where to find relevant information.

Records were stored securely. Electronic records were password protected and only accessible to staff who needed to see them. Paper records were locked away in the nurses' station and clinic room on each ward.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the medication charts for all the patients on both wards and did not identify any prescription or administration errors. All patients had valid Mental Health Act documentation to authorise their medication where required. Nursing and medical staff undertook training and competency assessment in relation to medication management. On Bronte ward all nursing staff were up to date with their medication training and on Shelley ward 88% of staff were up to date with this training.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. During the ward rounds we observed, the patients' medication was reviewed by their responsible clinician and they were asked about any side effects they were experiencing and given relevant advice.

Staff completed medicines records accurately and kept them up-to-date. All the prescription charts we reviewed were accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. Medication and prescription charts were stored safely in both clinic rooms. The hospital's pharmacy provider carried out monthly audits of medication storage and action was taken in response to any issues the audits identified. The October 2022 audit on Bronte ward identified 2 occasions where the temperature of the medication fridge had not been documented. We also identified 1 missing temperature check of the medication fridge on this ward.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. The records we reviewed all showed that the patient had their medicines reviewed when they were admitted to the ward.

Staff learned from safety alerts and incidents to improve practice. We saw evidence of learning from medication incidents being reviewed and fed back to staff in the minutes of governance meetings and ward team meetings.

Requires Improvement

Forensic inpatient or secure wards

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The use of as required (PRN) medication was audited by the hospital's pharmacy provider monthly. The October 2022 audit for both wards did not identify any concerns about excessive use of PRN medication.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. There were no patients at the hospital taking high dose anti-psychotic treatment at the time we inspected. Where patients were taking medication which required ongoing monitoring of their physical health we saw that this was taking place at the required intervals.

Track record on safety

The service had a good track record on safety.

No serious incidents had occurred on Bronte ward in the 12 months preceding our inspection. On Shelley ward 4 serious incidents had occurred (the safeguarding incidents referred to above). There had been no patient deaths or serious injuries at the hospital since our last inspection.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All the staff we spoke with knew how to report an incident on the ward's online system. Staff could give examples of the types of events which should be reported as incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. Incident data was reported on the provider's system and were reviewed at the daily multi-disciplinary team meetings in relation to each patient.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported patients after any serious incident. Records of post incident de-briefs were recorded in the care records of the individual patient involved. However, as no separate records of post-incident de-briefs were available for Bronte and Shelley wards, we were not able to see how well staff had been supported following incidents which may have been difficult for them.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incident records showed that incidents were investigated and the investigations included feedback from the patient involved where relevant. Staff were suspended from work where this was necessary to ensure patient safety while the investigation was being carried out. Following recent incidents there were 15 members of staff on suspension at the time we inspected the hospital.

Requires Improvement

Forensic inpatient or secure wards

Staff received feedback from investigation of incidents, both internal and external to the service. The staff we spoke with told us that they received email updates which included lessons learned from incidents. The provider maintained a lessons learned log and produced update bulletins for staff with information about lessons learned from serious incidents at the hospital and in other Cygnet and NHS mental health services.

Staff met to discuss the feedback and look at improvements to patient care. Lessons learned from incidents were discussed at team meetings on both wards.

There was evidence that changes had been made as a result of feedback. We saw evidence of improvements having been made at the hospital as a result of learning from incidents, for example a trend in incidents of missed observations had been identified on Bronte ward in October 2022 and the provider responded to this by providing refresher training to staff and circulating the provider's policy on observations to remind staff of their responsibilities.

Managers shared learning with their staff about never events that happened elsewhere. The information shared with staff about lessons learned from incidents included details of serious incidents which happened elsewhere within the mental health system.

Is the service effective?

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan. However, care plans did not always clearly reflect the views of the patient.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed every patient's care records and they all included a comprehensive assessment of the individual's mental health needs which informed their care plans.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. All the records we reviewed included an assessment of the individual's physical health needs. Any change to patients' physical health were discussed at the handover and multi-disciplinary team meetings we observed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. All the records we reviewed included up to date care plans in relation to their identified mental and physical healthcare needs.

Staff regularly reviewed and updated care plans when patients' needs changed. Changes to people's needs were reviewed at the multi-disciplinary team and ward rounds we observed and their records were updated during the meetings.

Care plans were usually personalised, holistic and recovery-orientated. However, one care plan on Shelley ward did not include evidence of the patient's views about their care and three of the people we spoke with said they did not feel involved in the creation and ongoing review of their care plans.

Requires Improvement

Forensic inpatient or secure wards

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. People were receiving care from a full multi-disciplinary team including psychiatrist, nursing support, psychology and occupational therapy.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE). Both wards followed Cygnet's model of care for secure and forensic services which was in line with up to date national best practice guidance. At the ward rounds we observed the patient's progress in relation to the model of care was reviewed and the patient's understanding of their progress was checked.

Staff identified patients' physical health needs and recorded them in their care plans. People had specific care plans in relation to any long term conditions they had, like asthma or diabetes. There was a physical healthcare nurse who worked at the hospital and who contributed to care planning and reviews for people with long term conditions.

Staff made sure patients had access to physical health care, including specialists as required. The patients we spoke with told us that they were happy with the care they were receiving for their physical health, including some people with long term conditions. All the patients on both wards were registered with a GP and the records showed that staff supported people to access physical healthcare as needed. The on-site physical healthcare nurse also provided advice and interventions to people as needed. There were some issues with patients accessing dental care in line with general challenges in the local area but staff were doing what they could to support people to access a dentist.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Most patients told us they liked the food and there were healthy choices available. Care records showed that people's nutrition and hydration needs were assessed and support was provided as needed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There were activities available at the hospital which promoted physical and mental health including a walking group and relaxation sessions and records showed that patients were taking part in these.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The hospital used the Cygnet-wide Global Assessment of Progress scale against which people's care and treatment outcomes were monitored.

Staff used technology to support patients. The hospital had a relaxation room which was shared by both wards. This included light and sound equipment in order to create a relaxing atmosphere. We observed patients enjoying this during our inspection and some patients told us it really supported them to feel calmer. We also observed the use of technology to support communication and collaboration in relation to people's care as commissioners and other external stakeholders were able to dial in to ward rounds remotely using video conferencing.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, an annual audit was carried out, most recently in June 2022, to assess the effectiveness of the psychology service at the hospital against its service specification. Also START risk assessment completion was audited on both wards in August 2022 with a range of staff including support workers taking part in these audits.

Managers used results from audits to make improvements. Action plans were implemented to address the issues identified by the audits we saw. The 2022 START risk assessment audit identified improvements in risk assessment completion on both wards compared to the 2021 audit.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new permanent staff. However, we did not always see evidence that agency workers received an appropriate induction and not all staff were up to date with their clinical supervision.

The service had a full range of specialists to meet the needs of the patients on the ward. The hospital had a well-established multi-disciplinary team at the time we inspected including a dedicated consultant psychiatrist for each ward and teams of psychologists and occupational therapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The skills, qualifications and experience of permanent staff were assessed through Cygnet's centralised recruitment system. The qualifications and recent training records of bank and agency staff were identified on the online booking system used at the hospital and the system prevented the wards from booking staff who were not suitably trained.

Managers gave each new member of permanent staff a full induction to the service before they started work, but we did not always see evidence that agency staff had received an appropriate induction. All the staff we spoke with told us they had received an induction and the provider kept a spreadsheet to identify which members of agency staff had received an induction to each ward. However, the copy of the spreadsheet on Shelley ward was dated 17 October and there was no copy available on Bronte ward during our inspection. Staff told us if they were unsure of whether an agency worker had received an induction to their ward they would call the hospital's receptionist who always had access to the up to date spreadsheet. We asked the provider to send us the induction records of the last 5 agency workers who worked at the hospital. Of these 5 workers only 2 had received an induction specific to the ward they were working on.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. On Shelley ward 82% and on Bronte ward 89% of staff had received an appraisal within the last 12 months. All allied health professionals at the hospital had received an appraisal within the last 12 months.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. All permanent medical staff at the hospital had received an appraisal within the last 12 months when we inspected.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. The staff we spoke with told us they were receiving regular supervision. The wards displayed a chart showing the members of staff responsible for providing supervision. The identified supervisor for some support workers was a nurse who was suspended at the time of the inspection with no return to work date set. On Shelley ward 80% of staff were up to date with clinical supervision and on Bronte ward 88% of staff were up to date at the time we inspected. The hospital's psychologists and social workers were 100% up to date with their clinical supervision, however only 75% of the occupational therapists were up to date.

Managers supported medical staff through regular, constructive clinical supervision of their work. The doctors we spoke with told us they had access to clinical supervision from senior clinicians within the Cygnet group. All the doctors working at the hospital were up to date with their clinical supervision at the time we inspected.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff told us they were able to attend team meetings and they received an email with the information from meetings they had not been able to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The provider's appraisal template included prompts for training needs to be discussed. The staff we spoke with said they felt well supported by the provider in relation to training and development.

Managers made sure staff received any specialist training for their role. For example, 42 members of staff at the hospital had been provided with nasogastric feeding training due to the needs of an individual patient.

Managers recognised poor performance, could identify the reasons and dealt with these. The managers we spoke with discussed how concerns about staff performance were picked up through supervision and from incidents or complaints and we saw that appropriate action was taken to support staff and/or to address the concerns through disciplinary action. We also saw evidence that the hospital managers reported significant concerns about staff conduct to the appropriate authorities in a timely way.

There were no volunteers working at the hospital at the time of our inspection.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multi-disciplinary meetings took place every weekday morning on each ward. We observed 2 of these during the inspection and saw that each patient was reviewed and changes made to their care to adjust to their ongoing needs.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed 2 handover meetings at which each patient was briefly reviewed by reference to a written handover summary. The nurse on the commencing shift took notes and all attendees were attentive throughout the meeting. However, on Bronte ward 1 support worker was not able to attend the handover meeting because they had been undertaking security checks at the same time.

Ward teams had effective working relationships with other teams in the organisation. We saw good partnership working across the hospital, for example to ensure staffing levels and skill mix were appropriate on both wards. We observed positive working relationships between ward staff and other teams who were on site during our inspection, for example facilities.

Ward teams had effective working relationships with external teams and organisations. The multi-disciplinary team invited representatives of other agencies including commissioners, care co-ordinators and the Ministry of Justice to attend patients' ward rounds.

Requires Improvement

Forensic inpatient or secure wards

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

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. On both wards and across all staff groups 100% of staff were up to date with their Mental Health Act mandatory training at the time we inspected.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had a Mental Health Act administrator who staff could access for support and advice as needed.

Staff knew who their Mental Health Act administrators were and when to ask them for support. All the staff we spoke with were aware of how to contact the Mental Health Act administrator for advice and said they would feel comfortable doing so.

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. Staff were able to access the provider's Mental Health Act policy via the intranet from both wards.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There were 2 Independent Mental Health Advocates who visited the hospital. Both came on site during our inspection and told us that they visited weekly and met with all the patients who wished to speak with them.

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. Records showed that staff were reminding people of their rights under the Mental Health Act at the required intervals and the patients we spoke with confirmed they were given information about their rights in a way they could understand.

Staff usually 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. Most of the people we spoke with said they were not having their section 17 leave cancelled due to staffing shortages. Leave records showed that people were regularly accessing leave. However, two of the patients on Shelley ward said they could not always access their section 17 leave when they wished to, due to the need for a male member of staff to accompany them and/or the need for a male to remain present on the ward.

Where patients were not granted section 17 leave this was usually justified on the basis of risk, however this was not always the case. One patient had not had any section 17 leave other than medical leave since May 2022 following incidents of aggression. The Ministry of Justice had not been contacted and asked to review the suspension of this individual's leave even though the patient had not been involved in any violent incidents since this time.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Where people had not consented to their treatment there was always an up to date authorisation from a SOAD with their prescription chart.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. The Mental Health Act administrator kept the paper copies of people's detention records and staff were aware of how to access them.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. All the records we reviewed included a discharge plan which included information about section 117 aftercare for people who were nearing the point of discharge.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Six monthly audits were carried out in relation to Mental Health Act compliance on both wards, most recently in July 2022. Action plans were implemented to address any issues identified by audits.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. The staff we spoke with confirmed they had received training on the Mental Capacity Act and were able to give examples of the underlying principles such as the assumption of capacity in the first instance. Staff on Shelley ward and all doctors, psychologists and occupational therapists were up to date with their Mental Capacity Act training at the time we inspected and on Bronte ward 96% of staff were up to date.

There were no deprivation of liberty safeguards applications made from Bronte and Shelley wards in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff could access the provider's Mental Capacity Act policy from both wards via the provider's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The Mental Health Act administrator was also available to give advice in relation to the Mental Capacity Act and staff were aware of this.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. People had care plans in relation to communication needs where this was relevant to their care.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. All the records we reviewed included documented capacity assessments in relation to significant decisions.

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. At one of the multi-disciplinary meetings we observed there was a discussion about a patient who may lack the capacity to make certain decisions and a plan for the assessment of their capacity was made which included a consideration of the patient's views and the potential impact on them of any action taken without their consent.

Requires Improvement

Forensic inpatient or secure wards

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. The last Mental Capacity Act audit at the hospital took place in September 2022. However this only involved the review of 2 patients' records rather than the recommended number of 5 sets of records.

Is the service caring?

Requires Improvement

Kindness, privacy, dignity, respect, compassion and support

Staff usually treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed positive and supportive interactions between staff and patients on both wards throughout our inspection. The patients we spoke with all told us that staff usually treated them with respect and there was generally a member of staff around if they needed someone.

Staff gave patients help, emotional support and advice when they needed it. The patients we spoke with told us that staff were supportive when they needed someone to talk to. We observed staff regularly checking in on patients, asking if they were ok if they seemed distressed.

Staff supported patients to understand and manage their own care treatment or condition. We observed staff supporting people to understand their condition during ward rounds.

Patients said staff treated them well and behaved kindly. Most of the patients we spoke with told us that staff treated them kindly. None of the patients complained about experiencing abusive behaviour from staff. However, some patients found the security restrictions challenging and said they felt like staff were following them everywhere. We saw that this had also been raised in community meetings on the ward and reassurance had been offered to patients about the purpose of observations and security checks on the ward.

Staff understood and respected the individual needs of each patient. People's individual needs were discussed at handover meetings and we observed staff providing individualised care to people, taking their needs and preferences into account.

Patients had access to mobile phones to keep in contact with relatives but due to security considerations they did not have their own smart phones and so could not make video calls to relatives. Staff and patients told us that video calls were not usually facilitated for patients using any shared technology either.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All the staff we spoke with told us they would feel confident to raise a concern about abusive or inappropriate conduct towards patients. A number of concerns had been identified about staff conduct since our last inspection due to concerns raised by colleagues who observed care they felt was not appropriate.

Staff followed policy to keep patient information confidential. We did not observe any staff discussing confidential information about patients where others could overhear. The patients we spoke with did not raise any concerns about their confidential information being shared inappropriately.

Requires Improvement

Forensic inpatient or secure wards

Involvement in care

Staff actively sought patients' feedback on the quality of care provided and ensured that patients had easy access to independent advocates. However, patients were not always sufficiently involved in care planning.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients received a welcome pack when they were admitted to the ward which included information about mealtimes, activities, the local area, the nursing and therapy support available, restricted items and patients' rights under the Mental Health Act.

Staff did not always involve patients and give them access to their care planning and risk assessments. Some people told us that they did not feel sufficiently involved in their care and the records we reviewed did not always include a clear record of the individual's views.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Where people needed interpreters or accessible written information due to language needs or disability these were provided.

Staff involved patients in decisions about the service, when appropriate. There were community meetings taking place weekly on both wards at which patients could raise concerns and share their views about the running of the ward. We saw evidence from the minutes of these meetings that action was usually taken to address the issues raised and to accommodate patients' requests where possible. A people's council also took place once a month where staff and patients from the whole hospital met to discuss any issues patients wished to raise.

Patients could give feedback on the service and their treatment and staff supported them to do this. The minutes of the community and people's council meetings showed that staff were supporting patients to share their views on a range of aspects of the service including food, activities, the ward environment and blanket restrictions. No patients attended the October 2022 people's council and the hospital responded to this by offering food and drinks at the November 2022 people's council to promote attendance by more patients, which was successful.

Staff supported patients to make advanced decisions on their care. People had advanced decisions documented on their records where this was something they had wished to do.

Staff made sure patients could access advocacy services. Independent advocates attended both wards weekly and both the advocates attended the hospital during our inspection. The patients we spoke with who had wanted to speak to an advocate confirmed they had been able to. The advocacy service prepared monthly reports for the service, the most recent of which showed that 62 advocacy sessions had taken place at the hospital in October 2022 (across 3 wards).

Involvement of families and carers

Relatives and carers were not always fully involved in patients' care. However, the provider had recognised this and was working to implement an action plan for the improvement of carer involvement on both wards.

Staff supported, informed and involved families or carers. We were not able to obtain any direct feedback from relatives or carers during this inspection and the hospital manager acknowledged that carer involvement was a challenge for the hospital. However, the provider was working to an action plan to improve carer engagement and had a number of initiatives planned including a carers' event to take place in December 2022 alongside a Christmas market event planned for patients and awareness raising with staff about the importance of carer involvement.

Requires Improvement

Forensic inpatient or secure wards

Staff helped families to give feedback on the service. The hospital carried out 3 monthly reviews of the NHS Friends and Family Test feedback responses received from carers and relatives. From June to September 2022, 4 relatives completed the test. The only negative feedback received during this period related to how easy it was for relatives to get information from the hospital.

Staff gave carers information on how to find the carer's assessment. When patients were admitted to the hospital the service sent any relatives involved in their care an information pack which included details of how to access a carer's assessment.

Is the service responsive?

Requires Improvement

Access and discharge

Staff worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave. However, the length of stay for both wards was over the national average for low secure services.

Bed management

Managers made sure bed occupancy did not go above 85%. There were vacant rooms on both wards to allow for emergency admissions as required within the wider healthcare system. In the three months preceding our inspection the average occupancy for Shelley ward was 75% and for Bronte ward was 67%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Each patient had their length of stay clearly identified on their electronic records and the length of stay was included in the information reviewed at the ward rounds we observed. The average length of stay on Bronte ward for the 12 months preceding our inspection was 36 months and for Shelley ward it was 57 months (73% of patients across both low secure wards had a length of stay of over 18 months at the time we inspected).

The service had mostly out-of-area placements. People told us that it was difficult to keep in contact with their families due to not being situated within their home area.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. One patient was nearing discharge and was on long term section 17 leave at the time we inspected – they still had their own bedroom at the hospital even though they never slept on the ward.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Due to the two wards being gender specific, patients were never moved between the wards at the hospital which remained open at the time of our inspection.

Staff did not move or discharge patients at night or very early in the morning. We saw no evidence from our review of the care records that any patients had been moved or discharged from either ward at inappropriate times of day.

Requires Improvement

Forensic inpatient or secure wards

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Only one of the patients was ready for discharge and experiencing a delay in relation to this. This was due to difficulties in arranging necessary ongoing community care and we saw that the provider was making considerable efforts to resolve these issues so the patient did not have to stay in hospital for longer than necessary. We were informed shortly following our inspection that the patient had been successfully discharged.

Patients did not have to stay in hospital when they were well enough to leave. The only patient who was ready for discharge at the time of our inspection was on long term section 17 leave and was just attending the hospital as an outpatient for necessary care.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. All the records we reviewed included a discharge plan and the progress of individual patients towards discharge was reviewed at both the ward rounds we observed. Care managers and coordinators were invited to attend ward rounds and attended remotely using videoconferencing where possible. However, some external stakeholders told us that they felt communication by the hospital in relation to changes to patients' discharge plans could be more proactive as they generally had to wait for ward rounds to be made aware of changes.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom, however not all patients had a key to their room. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Not all the patients on Shelley ward had a key for their room and some of these patients said they would like their own key. Staff confirmed there was no risk related reason why these patients could not have a key to their room.

Patients had a secure place to store personal possessions. All the bedrooms had a safe in which patients could store items securely.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. There were activity rooms on both wards and additional rooms shared by the wards including an occupational therapy kitchen, a gym, a sensory room and a multi-faith room. Patients particularly gave positive feedback about the sensory room and said they enjoyed spending time there.

The service had quiet areas and a room where patients could meet with visitors in private. Both wards had quiet lounges and there was also a relaxation room and visitor's room off the wards, both of which patients could access with support from staff.

Patients could make phone calls in private. Patients had their own mobile phones which they could use to keep in touch with friends and family. Patients could also borrow the portable ward phone if they did not have any credit on their own phone and we observed a patient being supported to do this during our time on Bronte ward.

The service had an outside space that patients could access easily. Both wards had adjacent courtyards which patients could access with support from staff. Staff and patients told us that patients could access the outside space at all times of day on request.

Patients could make their own hot drinks and snacks and were not dependent on staff. There were tea and coffee making facilities on both wards which patients could access independently.

The service offered a variety of good quality food. Most of the patients we spoke with said they enjoyed the food and there was a good variety of options including vegetarian and Halal meals.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Educational opportunities were available on the ward including functional skills, maths and English lessons. We also saw that some patients were being supported to access other online courses they were interested in although in some cases there had been delays in relation to this which had been frustrating for the individuals concerned. Patients could also undertake paid work in the on site tuck shop and as ward representatives if they wished to and were well enough.

Staff helped patients to stay in contact with families and carers. People's relatives could visit the hospital and some patients were able to have escorted leave with relatives. However where people were situated a long distance from their families they were not always being supported to have contact through video calls as they did not have smart phones due to security restrictions.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. A range of group activities and therapeutic sessions were arranged by the psychology and occupational therapy teams to encourage people to socialise on the wards and we saw positive interactions between peers on the wards.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Both wards were fully accessible to wheelchair users and patients were being supported to access support in relation to any specific communication needs they had, for example due to hearing impairment.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information was displayed on noticeboards on both wards and all patients received an information pack when they were admitted to the wards. Written information was available in easy read format as required.

The service had information leaflets available in languages spoken by the patients and local community. These were available on request from a bank of leaflets in different languages held centrally by Cygnet.

Managers made sure staff and patients could get help from interpreters or signers when needed. The ward managers confirmed that if patients needed an interpreter this could be arranged for their ward rounds and other occasions as required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The menus had a selection of Halal and vegetarian options and all the patients we spoke with said they were able to access food which met their individual needs.

Requires Improvement

Forensic inpatient or secure wards

Patients had access to spiritual, religious and cultural support. The hospital had a multi-faith room which patients could access with support from staff. The patients we spoke with did not raise any concerns about their cultural or spiritual needs not being met.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The people we spoke with confirmed they knew how to make a complaint about their care. However, the written information provided to people on admission did not include any information about how to raise concerns about the hospital.

The service clearly displayed information about how to raise a concern in patient areas. There was information about the complaints process displayed on the noticeboards of both wards.

Staff understood the policy on complaints and knew how to handle them. Staff could access the complaints policy via the intranet. The staff we spoke with were aware of how to deal with complaints from patients.

Managers investigated complaints and identified themes. Complaints data including any identified trends of concern were reviewed by the provider at monthly local and regional governance meetings.

Staff protected patients who raised concerns or complaints from discrimination and harassment. None of the people we spoke with had experienced discrimination because they had raised concerns about their care. Complaints were investigated by staff members who were independent to the concerns raised, including by managers from a different hospital where required.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Action was taken in response to upheld complaints to resolve the issue and/or prevent a recurrence.

Managers shared feedback from complaints with staff and learning was used to improve the service. Lessons learned from complaints were fed back to staff at team meetings.

The service used compliments to learn, celebrate success and improve the quality of care. A register of compliments was kept and the learning from these was fed back to staff at team meetings.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. Although the hospital had not had a registered manager in post

since June 2022, there was a hospital manager in post who told us they intended to apply for CQC registration as soon as possible. The hospital manager worked closely with both ward managers and other senior members of the multi-disciplinary team. At the time we inspected there was a vacancy for a clinical manager at the hospital, however we saw that the provider was taking action to address this.

Leaders worked hard to instill a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. Following our previous inspection we identified concerns about the culture at the hospital. The provider had taken significant action to investigate and address these concerns including some staff being suspended, additional governance and assurance checks being implemented on the wards and support being provided for staff including reflective practice sessions, training and supervision. We did not identify any concerns about the culture on either ward during this inspection. Staff and patients we spoke with told us that they felt the hospital's culture had improved under the new manager's leadership.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. Both ward managers were visible on the wards, interacting with patients and staff. We also saw senior managers spending time on the wards and ward staff and patients told us that this was now happening much more frequently.

Leaders and senior staff were alert to the culture in the service and as part of this spent time with staff/ people and family discussing behaviours and values. In response to the previous concerns about the culture on the wards the provider had arranged a series of values-based interviews with staff as part of a culture review.

Managers did not always promote equality and diversity in all aspects of running the service. Some staff told us they did not feel they had equal opportunities for progression due to their race. We asked the provider to share some examples of how equality and diversity was promoted within the service within the past 12 months with us and the only information shared was Cygnet's equality and diversity policy and a wall mural stating "diversity is our strength".

The 2022 staff survey for the hospital, which was completed by 45% of the hospital's staff, showed that 12% of respondents had experienced discrimination from a manager and 18% had experienced discrimination from a colleague. Of those who had experienced discrimination, 80% said it was on the basis of their race.

Only 47% of respondents to the survey agreed with the statement "Cygnet acts fairly with regards to suspensions and/or disciplinary procedures regardless of age, disability, gender reassignment, sexual orientation, marriage or civil partnership, pregnancy and maternity, race, religion and belief or sex" and only 42% of respondents agreed with the statement "Cygnet provides equal opportunities for career progression and promotion".

In the 12 months prior to our inspection 75% of grievances raised by staff related to racial discrimination or abuse.

Vision and strategy

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

Most of the staff we spoke with were aware of Cygnet's organisational values which are Integrity, Trust, Empower, Respect and Care. The ward managers and hospital managers described how they worked with staff through team meetings and one to one supervision to support them to understand how the values applied to their work in a meaningful way. Staff engagement with the provider's values was formally reviewed as part of their annual appraisal.

Requires Improvement

Forensic inpatient or secure wards

Culture

Staff did not always feel respected, supported and valued but they did always feel they could raise any concerns without fear. Some staff said they did not feel they had equality of opportunity due to their race.

Staff always felt able to raise concerns with managers without fear of what might happen as a result. The service had a Freedom to Speak Up Guardian who visited the hospital during our inspection.

Staff did not always feel respected, supported and valued by senior leaders. In the hospital's 2022 staff survey there had been a significant decrease in the proportion of staff who stated they enjoyed their work, were comfortable with their workload and felt they had an opportunity to contribute ideas. Also 19% of staff stated that they had experienced harassment or bullying from a manager or team leader in the last 12 months. However, the staff we spoke with during the inspection said they felt the culture of the hospital had improved recently and they felt like the new manager and other senior staff were supportive.

Governance

Our findings from the other key questions mostly demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance processes were effective and helped to hold staff to account, kept people safe, protected their rights and provided good quality care and support. Local and regional governance meetings took place regularly at which a range of quality and safety information about the hospital were reviewed.

The provider kept up to date with national policy to inform improvements to the service. Developments in national mental health policy were discussed at regional and local governance meetings and used to inform developments to the service.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes. A range of audits including records, medicines management and environmental checks took place regularly and action plans were written to address any issues they identified. However, the action plans we saw did not clearly identify the person responsible for implementing each action or a timescale for completion, which created a risk that actions would not be progressed in a timely manner.

The management of records and recordings of surveillance ensured they were protected and stored safely. Records had been kept in line with the provider's policy of all stored images from the CCTV which were required due to ongoing incident investigations.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed. The multi-disciplinary teams on each ward met each morning to review the care of each patient and changes were made to adjust to people's changing needs.

Requires Improvement

Forensic inpatient or secure wards

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. The hospital had a risk register to highlight the key organisational risks relevant to the service and this was regularly reviewed. The risks arising from the closure of 2 wards and the redeployment of staff to services they were new to working in had been included within the risk register. Actions had been taken to mitigate the impact of this including provision of additional training and management of rotas to ensure shifts included a mixture of experienced and less experienced staff.

Staff acted in line with best practice, policies and procedures. They understood the importance of quality assurance in maintaining good standards. Staff completed an induction which included training on the hospital's key policies and procedures and took part in the hospital's quality assurance processes such as audits. Lessons learned from audits, incidents and other governance data were fed back to ward staff at team meetings.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Data about the outcomes for individuals and findings from quality assurance processes at the hospital were reviewed at regional governance meetings.

Engagement

Managers engaged other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff encouraged people to be involved in the development of the service. A people's council was held during our inspection. As no patients had attended the previous people's council staff arranged for food and drinks to be provided to make it more attractive for people to attend and some patients did take part in the meeting held while we were on site.

The provider sought feedback from people and those important to them and used the feedback to develop the service. Patient and relative surveys were carried out and people were also able to raise verbal feedback at weekly community meetings which took place on both wards.

The service worked well in partnership with advocacy organisations, which helped to give people using the service a voice. Independent advocates attended both wards several days a week and the advocacy provider shared monthly reports with the hospital to enable monitoring of the uptake of the advocacy service.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership. Since our last inspection a quality improvement group had been taking place monthly with involvement from a range of commissioning organisations as well as the local safeguarding team and CQC. Representatives from the hospital had engaged with this process and worked to implement the action plan reviewed at the monthly group meetings.

Learning, continuous improvement and innovation

The provider kept up-to-date with national policy to inform improvements to the service. At the time of our inspection the provider was participating in the voluntary peer review process offered by the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services. There was also an ongoing local improvement project in relation to carer and relative involvement.

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

Inadequate

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

As the psychiatric intensive care unit was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Is the service effective?

Requires Improvement

As the psychiatric intensive care unit was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Is the service caring?

Requires Improvement

As the psychiatric intensive care unit was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Is the service well-led?

Inadequate

As the psychiatric intensive care unit was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Inadequate

Personality disorder services

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

As the personality disorder service was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Is the service effective?

Requires Improvement

As the personality disorder service was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Is the service caring?

Requires Improvement

As the personality disorder service was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

Is the service well-led?

Inadequate

As the personality disorder service was closed at the time of this inspection, this core service was not inspected, therefore the previous rating remains.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service must ensure that all patients have access to regular one to one support from a named nurse who is not on long term absence from the hospital. (Regulation 9 (1) (b))

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 The service must ensure that a consistent approach is taken to the management of ligature risks on both wards to meet the needs of the patients. (Regulation 12 (2) (b)) The service must ensure that individuals have their care plans reviewed following incidents of self-harm to ensure they are provided with care and support to mitigate the risk of a similar incident recurring as far as reasonably practicable. (Regulation 12 (2) (b)) The service must ensure that all areas of the hospital are kept clean and records are maintained to provide assurance that cleaning is taking place. (Regulation 12 (2) (d)) The service must ensure that all staff receive regularly updated training on emergency life support at a level appropriate for their role. (Regulation 12 (2) (c))

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service must ensure that patients are protected from any further abuse by staff, that investigations continue in conjunction with local police and safeguarding teams in relation to the allegations of patient abuse on Shelley ward and that action is taken in relation to any substantiated concerns about abuse to hold the perpetrators to account and prevent a recurrence. (Regulation 13 (1) and (3)) The service must ensure that patients do not have their right to section 17 leave from the hospital restricted more than is necessary on the basis of risk. (Regulation 13 (5)) The service must ensure that patients can have a key to their bedroom unless this is not appropriate on the basis of individually assessed risk. (Regulation 13 (5))
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that all bank and agency staff receive a ward-specific induction prior to commencing work on any ward at the hospital. (Regulation 18 (2) (a)) The service must ensure that staff do not experience discrimination on the grounds of any protected characteristics and that action is taken in relation to the ongoing concerns raised by staff about experiencing racial discrimination at work. (Regulation 18 (2) (a))