Coveberry Limited

Eldertree Lodge

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services caring?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Eldertree Lodge is an independent mental health hospital provided by Coveberry Limited. It is a 41-bed hospital providing specialist inpatient treatment and longer-term high dependency rehabilitation services for adults aged 18 years and over in locked wards specifically for patients with a learning disability or autism. Coveberry Limited also provide a supported living service, Oakwood House, through the registration of personal care at Eldertree Lodge. Oakwood House was not visited as part of this inspection. An inspection of Oakwood House is planned and upon completion the inspection report will be available on our website www.cqc.org.uk.

On 23 and 25 March 2021, we completed an unannounced, focused inspection of Eldertree Lodge in response to information of concern about the care and treatment provided there.

Following the inspection, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within 24 hours that described how it was addressing our concerns. Their response did not provide enough assurance they had acted to address immediate concerns.

Due to the serious nature of the concerns we found during this inspection, we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and imposed additional conditions on the provider's registration. This included a condition to restrict the provider from admitting any new patients to Eldertree Lodge without the prior written agreement of the Care Quality Commission.

This inspection rated Eldertree Lodge inadequate and placed it into special measures.

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

This inspection which commenced on 20 May 2021 was an unannounced, focussed inspection to see what improvements the provider had made. Our inspection focussed on the concerns we raised to the provider following our previous inspection.

Following the 20 May 2021 site visit, we issued the provider with a requirement to provide documentation and closed circuit television recordings specific to high level incidents of restraint and incidents where a patient had made an allegation against a member of staff causing harm. We made this request because we identified concerns about the use of restraint with patients. The requirement was issued under Section 64 of the Health and Social Care Act 2008.

On receipt of this information, we carried out a further unannounced site visit on 3 June 2021. During this visit we reviewed closed circuit television camera footage from six incidents specific to one ward from 27 February 2021 to 13 April 2021. We also looked at closed circuit television camera footage from eight incidents that occurred between 6 May 2021 and 14 May 2021. These incidents were randomly sampled from Ash, Chestnut and Birch wards.

Due to the seriousness of the concerns we identified during this inspection, we sent a letter to the provider detailing our concerns and giving them opportunity to provide documentary evidence that risks were being managed, and patients

Summary of findings

were safe. However, the provider's response did not fully address all areas of our concerns. We sent a further letter setting out our concerns and giving the provider another opportunity to provide assurances through documentary evidence. Again, the provider's response failed to address all areas of our concerns, provide adequate detail of risk management and assure us patients remained safe at the service.

On 14 June 2021, we sent the provider an urgent Notice of Decision detailing our decision to vary the provider's conditions of registration to remove regulated activities at Eldertree Lodge. The variation removed inpatient treatment and high-dependency rehabilitation services at Eldertree Lodge from 17 July 2021. The notice also detailed conditions on the provider's registration to ensure the removal of regulated activities was managed in a safe way for patients.

We made this decision because:

- We believed patients continued to be exposed to a risk of harm. Staff actions or omissions in care did not always protect patients from avoidable harm. Closed circuit television camera footage showed staff ill treatment and abuse of patients.
- Staff did not always manage incidents and behaviours that challenge well. Closed circuit television camera footage showed staff sometimes used inappropriate restrictive techniques with patients and behaved unprofessionally during incidents.
- Staff did not always safeguard patients from abuse. Staff failed to identify, record and notify actions or omissions in care that exposed patients to the risk of harm.
- We were not assured the provider always referred staff to registered bodies for further investigation following incidents of concern.
- Governance processes did not always work well. The provider's improvement plan did not demonstrate sufficient improvements. The provider's response to concerns raised to them did not provide assurance patients would remain safe from avoidable harm.
- Staff continued to not always use correct infection prevention and control measures to keep patients and staff safe. Staff continued to not always follow national COVID-19 guidance.
- We found a continuation that not all ward areas were clean, safe and well maintained. Many ward areas continued to have increased risks of slips and falls, ripped or broken furniture and damaged paintwork, and maintenance work had not always been completed to a good standard.
- We continued to find out of date food in ward kitchen areas.
- The provider continued to rely on temporary staff to maintain safe staffing of the hospital. The hospital did not always have enough appropriately skilled and experienced staff to ensure patient's needs were identified and met.
- The provider did not always make notifications to external bodies. Staff did not always record enough detail of the incidents and concerns they notified to external bodies.
- Staff did not treat patients with compassion and kindness. They did not respect patient's privacy and dignity. Not all staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Leaders did not have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff. Although the provider had introduced ward manager roles the impact of these roles was not seen.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	The summary is contained in the overall summary at the beginning of the report. Our rating of this service stayed the same.

Summary of findings

Contents

Summary of this inspection — Page

Background to Eldertree Lodge 6

Information about Eldertree Lodge 7

Our findings from this inspection

Overview of ratings 8

Our findings by main service 9

Summary of this inspection

Background to Eldertree Lodge

Eldertree Lodge is an independent mental health hospital provided by Coveberry Limited. Coveberry Limited registered as the provider of services in November 2020 following the acquisition of the location from another provider. It is a 41-bed hospital providing specialist inpatient treatment and longer-term high dependency rehabilitation services for adults aged 18 years and over in locked wards specifically for patients with a learning disability or autism.

Coveberry Limited also provide a supported living service, Oakwood House, through the registration of personal care at Eldertree Lodge.

Patients may present with a range of behaviours that are challenging, have a diagnosed mental health condition and drug and alcohol abuse. Patients may be detained under the Mental Health Act 1983 or subject to Deprivation of Liberty Safeguards. The service is commissioned by Clinical Commissioning Groups.

There were 26 patients admitted during the period of our inspection, of these three were on leave. The service did not have a CQC registered manager. However, the provider had an interim hospital director in place and active recruitment for the substantive hospital director position.

Eldertree Lodge provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Personal Care

The hospital has six wards:

Two admission and treatment units:

- Ash - female complex care, six beds
- Chestnut - male low functioning, six beds

Two rehabilitation wards:

- Willow - female complex care, seven beds
- Elm - male high functioning, seven beds

Two pre-discharge wards:

- Maple - male low functioning, seven beds
- Birch - male high functioning, eight bed

What people who use the service say

During our inspection visit on 20 May 2021, we had the opportunity to speak with one patient using the service. The patient told us they'd not seen many changes following our previous inspection. They believed there still was not enough staff which meant nurses did not always have time to spend with patients. They thought staff did not always help to keep the service clean.

Summary of this inspection

Feedback from the local advocacy service about patient experience was not always positive. We reviewed three pieces of patient feedback from June 2021. Patients didn't always feel safe and they didn't feel staff always listened to them. They identified staffing as a concern, particularly a lack of regular staff who knew them well.

How we carried out this inspection

Our inspection was an unannounced, focussed inspection to see what improvements the provider had made. The inspection comprised two site visits. Our inspection focussed on the concerns raised to the following our previous inspection. We did not look at all the key lines of enquiry.

The first site visit took place on 20 May 2021. The team that carried out this visit to the service comprised a lead inspector, a second inspector and an inspection manager.

Our second visit on 3 June 2021 was specifically to review closed circuit television camera footage of incidents that occurred in the hospital between February 2021 and May 2021. The team that carried out this visit to the service comprised a lead inspector and an inspection manager.

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

Following this inspection, we served the provider an urgent notice of decision under Section 31 of the Health and Social Care Act 2002, detailing our decision to vary the provider's conditions of registration to remove the following regulated activities at Eldertree Lodge:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The variation removed inpatient treatment and high-dependency rehabilitation services at Eldertree Lodge from 17 July 2021.

The notice also detailed conditions on the provider's registration to ensure the removal of the regulated activities was managed in a safe way for patients. We told the provider they must ensure patients are discharged safely and with appropriate clinical support. We told the provider that by 21 June 2021 they must not have more than 12 patients admitted to the service and by 16 July 2021 the provider must have no patients admitted. We were notified on 30 June 2021 that all patients had been safely discharged from the service.

We also required that the provider must ensure a registered trainer in their preferred restrictive technique reviewed all incidents of staff restraint of patients whilst patients remained at the service.

The final condition was the requirement of the provider to send us a weekly summary of all incidents and actions relating to restraint and any identified incidents of poor patient care. We also required the provider to share details of quality assurance monitoring activities and the details of patients discharged from the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Caring	Inadequate
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. We identified incidents of inappropriate restraint, abuse and ill treatment of patients. Staff did not have the skills to develop and implement good positive behaviour support plans and did not follow best practice in anticipating, de-escalating and managing challenging behaviour.

Use of restrictive interventions

Staff actions or omissions in care had not always protected patients from avoidable harm. We reviewed closed circuit television camera footage of six incidents identified by the provider as being of concern. The incidents were specific to one ward between 27 February 2021 and 13 April 2021. We saw multiple examples where staff pulled or dragged a patient in an attempt to move them to the ward seclusion room. In another example a staff member grabbed a patient from behind, again in an attempt to move them to the seclusion room. We saw two examples where staff slammed or forced doors shut on a patient without regard for the potential of their actions to injure the patient. All incidents demonstrated ill treatment or abuse and the use of inappropriate restrictive techniques by one or more of the staff members present.

We saw negative interactions from staff to patients, where staff became visible angry. We saw one example where a member of staff kicked a door open without due regard for the patient stood behind the door. In another example, eight members of staff surrounded a patient with intimidating body language, such as standing over them in a semi-circle, despite that it appeared the patient had de-escalated. This caused a further incident for the patient.

We saw multiple examples of staff attempting to seclude a patient without a clear reason for doing so. We saw staff did not always attempt to de-escalate prior to using restrictive techniques.

Staff did not always recognise the potential for their practice to harm patients. We looked at closed circuit television camera footage from eight incidents that occurred between 6 May 2021 and 14 May 2021. These were randomly sampled from three wards. In two incidents staff had not considered the environment in which they applied restrictive techniques. We saw risks from furniture and hard surfaces at proximity to the patient's head where staff applied techniques. We also saw staff used inappropriate restrictive techniques and on occasions appeared to apply excessive

force. The provider's timescale to ensure all staff were trained in the same restrictive techniques was not adequate to ensure patients were protected from a risk of harm at the earliest opportunity. For example, at May 2021, training amongst agency staff remained low with only 37% trained in the provider's recognised restrictive technique. However, staff reported they knew to only use the provider's recognised restrictive technique with patients.

The provider had introduced a Positive Behavioural Support project at the service. Staff spoke positively about additional Positive Behavioural Support training provided and believed restrictive practice had reduced as a result. In May 2021, the provider recorded 81% of permanent staff had completed Positive Behavioural Support training.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not recognise and report all incidents appropriately. Managers did not investigate all incidents thoroughly and lessons were not learned or shared with staff.

We found incidents of ill treatment or abuse of patients were not reported. Of the incidents we reviewed between 27 February 2021 and 13 April 2021, despite multiple staff involved in the incidents or a witness to the incidents, none of the ill treatment or abuse was reported. Incident records relating to these incidents were not accurate.The provider had completed an investigation in relation to the six incidents we reviewed. However, our review of the closed circuit television camera footage identified additional staff who either witnessed or were involved in the incidents. These staff failed to take action to safeguard the patient or record and report the incidents. Despite requests from CQC, the provider failed to provide detail of any actions to remove or investigate the conduct of these members of staff. We were not assured the provider had completed a thorough review and investigation of these incidents.

We reviewed records of four other incidents that occurred following our March 2021 inspection. Of these, three of the incident investigations recorded no lessons learned. Staff reported learning from incidents that occurred on other wards was not routinely shared, despite staff being required to work across multiple wards. We saw an email from senior leaders to staff on 14 May 2021 identifying the need to learn lessons from across the organisation and suggesting this practice had not yet started. The provider shared a blank lessons learned template in the email and proposed to use this with staff in the future. However, during this inspection we did not see completed templates or how staff used them.

Safe and clean care environments

Not all ward areas were clean, well maintained, well furnished and fit for purpose.

Ward environments appeared cleaner and the provider had purchased additional clinical and general waste bins. We saw additional housekeeping staff around the hospital and ward staff involved in cleaning activities. However, some ward areas continued to appear dirty, particularly ward baths and sinks. Cleaning records did not always demonstrate staff cleaned ward areas regularly. For example, we saw incomplete ward based two hourly touch point cleaning records.

The provider did not always maintain furniture in a good condition. In ward areas we continued to see examples of ripped or broken furniture and damaged paintwork on doors and skirting boards. However, the provider had existing plans to make environmental improvements to the buildings and told us the COVID-19 pandemic had caused delay.

Inadequate

Wards for people with learning disabilities or autism

We found the provider's improvement actions to reduce risks to patients from sharp mirror edges incomplete and without attention to detail. For example, a bathroom mirror on Maple ward remained unsealed with sharp edges exposed. On Ash ward we identified additional risks to patients from sharp notice board edges. The provider's improvement plan indicated actions to make sharp edges safe had been completed.

Increased risks of slips and falls remained in many ward areas. For example, missing laminate floorboards and pooling water in bathrooms on Elm ward. The provider had commenced improvements to ward floors and bathroom areas to prevent pooling water and actions remained ongoing.

Staff continued to not complete fridge temperature checks and we found out of date food remained in ward areas. This practice continued even though the provider had introduced additional staff actions to check ward kitchens and label food. This posed a risk patients would be exposed to food which was out of date.

We continued to find unlocked kitchen cupboards containing cleaning materials on Willow ward and paints left unattended on Elm ward. These practices continued despite additional staff training as part of the provider's improvement plan.

Staff continued not to follow infection control policy, including handwashing. The provider had an outbreak of COVID-19 at the service in April 2021. The outbreak was seen in staff across the site but was confined to four patients across two wards. The hospital moved out of outbreak status in May 2021. The provider was supported to manage the outbreak from infection prevention and control colleagues from external from Clinical Commissioning Groups and NHS England and NHS Improvement.

We saw some staff continued to not wear face masks correctly by wearing face masks below their nose or not covering their mouth. This practice continued despite a period of a COVID-19 outbreak and following the provider's actions to improve infection prevention and control practices in the hospital. Our review of closed circuit television camera footage between February 2021 and May 2021 further confirmed staff did not always use correct infection prevention and control measures to keep patients and staff safe from the risk of infection and COVID-19.

We did not see staff routinely practising good hand hygiene when moving around the hospital or when moving between patients to provide care and treatment. This practice continued even though the provider had increased the availability of hand sanitiser around the hospital and staff we spoke with knew when and how to use sanitisers. This meant patients and staff continued to be exposed to unnecessary infection and COVID-19 risks.

Personal protective equipment audits completed by the provider did not always demonstrate good staff practice and supported our site visit observations. For example, week commencing 3 May 2021 the provider recorded only 54% staff compliance with personal protective equipment. The provider's improvement plan included actions to improve compliance with personal protective equipment but we found the actions taken had not been effective.

Some staff continued to not be bare below the elbows. We saw ward staff wearing watches and long-sleeved clothing. This was not in line with national guidance for preventing the spread of infection. Wearing long sleeved clothing and items of jewellery or watches increases the risk of spreading infections, including COVID-19.

Information about social distancing continued to not always be visible in ward areas and staff continued to not always follow designated one-way systems when moving around wards. Safe room occupancy posters were missing from some ward areas and we saw room occupancy continued to be often greater than that assessed as safe. This practice was not in line with national guidance on social distancing and increased the risk of spreading COVID-19.

Inadequate

Wards for people with learning disabilities or autism

Wards continued to display little material in easily accessible formats to inform or engage patients. This included information about how to complain, activities and COVID-19 guidance. We saw empty notice boards on Elm ward and staff reported Chestnut ward's notice boards had been ripped down.

The provider told us one of their improvement actions to make the service more learning disability and autism friendly had been delayed because of the COVID-19 outbreak. However, the provider had not explored alternative ways to progress this action.

Seclusion room

Seclusion rooms now allowed clear observation but did not allow two-way communication.

Intercoms to aid communication in seclusions areas remained faulty. The provider had contacted the manufacturer after previous attempts to fix the intercoms had failed. The provider updated their improvement plan to indicate the action remained in progress.

The provider had improved visibility of the seclusion areas on Chestnut and Ash ward with the installation of additional convex mirrors.

Safe staffing

The service did not have enough nursing and medical staff who knew the patients.

The provider continued to rely on temporary staff to safely staff the hospital. This remained a concern despite actions by the provider to recruit permanent staff and reduce the number of temporary staff used. The provider reported 18 registered nurse vacancies, 6 senior support worker vacancies and two support worker vacancies. The provider had introduced a programme to reduce occupancy at the hospital. They believed reduced occupancy would ease pressure on staff and reduce the providers dependence on temporary staff. The provider's projected occupancy would be reduced to 20 patients by 1 June 2021. When we visited on 20 May 2021, the provider recorded actual staffing of wards exceeded required staffing by a total of four staff. Between March 2021 to present, the frequency of wards being understaffed had reduced. For example, In March 2021 6% of Ash ward's shifts had been understaffed compared with no recorded understaffing in May 2021 to date. Some staff believed not all wards were always sufficiently staffed to meet the needs of patients. For example, to meet patient observation levels. In one ward area we saw a member of staff continuously allocated to patient observations from 7:30am to 8pm.

When we visited on 20 May 2021, all the ward based nurses were agency staff. Some support staff reported nurses were not always familiar with patient needs and relied on support staff guidance. For example, in the management of behaviour that challenges. On the same day, agency support workers accounted for 43% of all ward based support staff. The provider reported many agency staff had worked at the hospital for several years and often maintained a consistent shift pattern on one ward.

The service remained without a Speech and Language Therapist despite the provider's continued recruitment efforts.

Are Wards for people with learning disabilities or autism caring?

Inadequate

Wards for people with learning disabilities or autism

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not treat patients with compassion and kindness. They did not respect patient's privacy and dignity. Not all staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

In our review of the closed circuit television camera footage of the six incidents between 27 February 2021 and 13 April 2021, we saw examples of unprofessional and abusive staff behaviour to patients. This included staff becoming visibly angry or threatening towards a patient, staff crowded around and standing over a patient held in restraint and staff displaying negative body language such as folded arms.

Staff did not always maintain the privacy patients during incidents. We looked at closed circuit television camera footage from eight incidents that occurred between 6 May 2021 and 14 May 2021. These were randomly sampled from three wards. Two incidents showed staff did not always protect the privacy, dignity and safety of patients actively being restricted by staff. On both occasions, staff did not redirect other patients from approaching the area where staff were already involved in restricting a patient. On another occasion another patient became actively involved in staff attempts to de-escalate a patient's behaviour.

We saw one example where a female patient became in a state of undress during an incident of restraint. Supporting staff did not attempt to protect the patient's dignity and continued to drag the patient towards the seclusion room. This patient was being restrained by several male members of staff and we did not see that female staff were swapped into the restraint team, despite being available on shift and being in the room during the incident of restraint.

Staff did not always appear to understand or assist patients to manage their condition. Our review of circuit television camera footage showed staff sometimes failed to recognise signs of a patient de-escalating from behaviour that challenges. Instead we saw staff continued to apply restrictive practices to restrain or seclude a patient. During our review of one incident, the provider agreed staff attempted to seclude a patient without good reason.

Staff did not always raise concerns about disrespectful, discriminatory or abusive behaviours towards patients. Staff involved in the incidents we reviewed had not raised concerns about the way staff treated a patient during an incident.

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

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Inadequate

Wards for people with learning disabilities or autism

Leaders did not have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.

Following our inspection in March 2021, the hospital director in post at that time resigned. The provider had an interim hospital director in place and active recruitment for the substantive hospital director position.

As part of the improvement plan the provider had reviewed leadership in the service. This introduced manager positions across five of the six wards. The provider had filled the ward manager positions with staff promotion from within the service and one position from external recruitment. However, when we inspected it was too soon for the provider to demonstrate the impact of ward manager roles.

Staff continued to report senior leaders were not always visible in the service and communication was poor. One staff member could not identify senior leaders to us. Staff reported senior leaders had not informed them of all our concerns following the inspection in March 2021 and had not engaged staff well in the planned improvements for the hospital.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and performance and risk were not managed well.

The provider failed to demonstrate sufficient improvements since the previous inspection in March 2021. Concerns remained in many areas including infection prevention and control practices, staffing, learning from incidents and the treatment of patients by staff. The provider's improvement plan was not always an accurate indicator of progress at the service. We found concerns remained in many areas where the provider indicated improvement actions had been completed. Some timescales for improvement did not provide assurance patients would remain safe during the interim period. For example, improvement actions to address staffing and skill mix concerns.

There were other areas where the provider failed to provide enough assurances to immediate concerns raised to them. This included failing to identify actions to protect and maintain patient's physical and mental wellbeing following inappropriate or abusive staff practices. Incidents notified to CQC following our site visits continued to raise concerns about staff's use of restrictive techniques with patients.

The provider did not always make timely referrals to registered bodies when staff actions or omissions in care caused harm to patients. For example, to the Disclosure and Barring Service and/or the Nursing and Midwifery Council. This risked staff with existing concerns about their practice being able to commence work in other care settings and exposing other patients to ill treatment or abuse. This was despite three requests from us to the provider to ensure these referrals were made.

Documentation from the provider did not always demonstrate staff made notifications to external bodies as needed. The provider did not report two incidents of restraint observed during our inspection visit on 25 March 2021 as part of our later request for information specific to high level incidents of restraint. The provider did not demonstrate they were addressing shortfalls in incident reporting at the service.

The provider's notifications to external bodies did not always provide enough detail of incidents or the scale of ill treatment or abuse some staff displayed in their actions to patients. This detail was also missing from the provider's weekly updates to external stakeholders.

Inadequate

Wards for people with learning disabilities or autism

The provider did not demonstrate how they met requirements of the Duty of Candour for patients who had been involved in inappropriate or abusive staff actions. The Duty of Candour is the responsibility for healthcare professionals to tell patients when something has gone wrong, apologise and offer appropriate remedy or support.

Following the inspection on 23 and 25 March 2021, external stakeholders, including representative from Clinical Commissioning Groups and NHS England and NHS Improvement, met twice weekly. In one, only external stakeholders met to provide updates on individual patients, progress with the provider and identify new or emerging themes. In the other, the provider joined the stakeholders to update them on their improvement plan and respond to questions from stakeholders.

Positive feedback from stakeholders included improved cleanliness of ward areas and the provider's ability to listen and often respond positively to concerns raised to them. Other feedback included some of the provider's reporting lacked quality and contained errors, lack of improvement in staff engagement and activity with patients was not always seen and a lack of documentation and care planning to support patient care. Other concerns raised included staffing numbers, the relationship between senior leaders and ward based staff and the ability of the provider to respond to immediate concerns while maintaining quality in other areas of the service.

Other stakeholder feedback about the provider was not always positive. One source identified staff omissions and neglectful behaviour in the care of a patient. The stakeholder found staff did not always do what they should be doing to support and care for patients and assurances from the provider could not always be relied upon.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care and did not use that information to good effect.

The provider identified conduct concerns for six staff members present or involved in the six incidents between 27 February 2021 and 13 April 2021. The provider acted to suspend these staff from duties pending further investigation. However, our review of the closed circuit television camera footage identified additional staff who either witnessed or were involved in the incidents. These staff failed to take action to safeguard the patient or record and report the incidents. Despite requests from CQC, the provider failed to provide detail of any actions to remove or investigate the conduct of these members of staff.

Following identification of staff conduct concerns present or involved in the six incidents between 27 February 2021 and 13 April 2021, the provider completed supervisions with 130 staff. We found the provider had issued a standardised supervision note to all staff. We saw no record of discussions about individual staff's practise to apply restrictive techniques or to identify and report safeguarding concerns. We were not assured the provider had taken enough action to ensure all staff involved in the incidents of concern were aware of their actions which were not appropriate. In addition to this, this did not provide assurance that staff members who failed to raise concerns in relation to inappropriate and/or abusive restraint were aware of importance of raising concerns to protect patients.

Culture

Staff did not feel respected, supported and valued. They did not feel they could raise all concerns without fear.

Inadequate

Wards for people with learning disabilities or autism

The provider's improvement plan and response to concerns raised to them did not identify proactive actions to reduce risks of a closed culture. A closed culture is a poor culture in a health or care service that increases the risk of harm including human rights abuses. Some staff we spoke with believed a culture of blame existed in the service. They felt the provider blamed front line staff for shortfalls in safety, quality and performance.

Some staff still did not feel confident to raise concerns within the service, instead reporting a preference to contact an external organisation such as CQC. Concerns remained that not all staff we spoke with were familiar with the provider's arrangements to support speaking up or raising a concern.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Following the inspection, an urgent Notice of Decision to impose and vary conditions on the provider's registration was issued under Section 31 of the Health and Social Care Act.** **The service provider had failed to ensure that persons employed who are registered with a health care or social care regulator, were enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continued to meet the professional standards which are a condition of their ability to practise or a requirement of their role. In particular:** • We were not assured the provider always referred staff to registered bodies for further investigation following incidents of concern.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Following the inspection, an urgent Notice of Decision to impose and vary conditions on the provider's registration was issued under Section 31 of the Health and Social Care Act.** **The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:**

This section is primarily information for the provider

Enforcement actions

- The provider did not always make notifications to external bodies. Staff did not always record enough detail of the incidents and concerns they notified to external bodies.
- Governance processes did not always work well. The provider's improvement plan did not demonstrate sufficient improvements. The provider's response to concerns raised to them did not provide assurance patients would remain safe from avoidable harm.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Following the inspection, an urgent Notice of Decision to impose and vary conditions on the provider's registration was issued under Section 31 of the Health and Social Care Act.** **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Staff actions or omissions in care did not always protect patients from avoidable harm. Closed circuit television camera footage showed staff ill treatment and abuse of patients. • Closed circuit television camera footage showed staff sometimes used inappropriate restrictive techniques with patients and behaved unprofessionally during incidents. • Staff did not always safeguard patients from abuse. Staff failed to identify, record and notify actions or omissions in care that exposed patients to the risk of harm. **There was insufficient mitigation of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular:**

This section is primarily information for the provider

Enforcement actions

- Staff continued to not always use correct infection prevention and control measures to keep patients and staff safe. Staff continued to not always follow national COVID-19 guidance

Inactive