Oaktree Manor

Quality Report

Heath Road, Tendring,
Clacton On Sea CO16 0BX
Tel:01255 871017
Website:www.partnershipsincare.co.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Oaktree Manor as **requires improvement** because:

- Staff did not always undertake reviews of patients in seclusion as per the provider's policy and Mental Health Act 1983 code of practice. For example, doctors did not always review patients within one hour of the seclusion starting. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.
- The provider had challenges with moving patients out of the hospital. The average length of stay for patients (now discharged) was 826 days, significantly longer than the national average of 554 days. Pine ward's average length of stay for patients was the highest with 1410 days.
- The provider had difficulties recruiting permanent nursing and healthcare workers. Staff vacancies had significantly increased since our last inspection.
- The number of staff restraints of patients had increased since our last inspection and several patients told us they did not like restraints taking place on the wards.
- The provider still had high and low-level ligature points across the hospital and lack of anti-barricade protection on some patient area doors which posed risks to patients with self-harming behaviours. Staff still could not easily observe patients on Rowan and Redwood wards due to the ward layout.
- Staff held patient records in paper and electronic files and some records were not easily accessible. Electronic records did not fully capture patients' involvement and views particularly on Maple and Pine wards.
- Several patients told us they did not like the food and there was not enough variety. They said they wanted more meaningful activities.
- Carers told us they did not always get updates from staff about the patient's care.
- The provider identified they had not developed their systems to address the workforce race equality standards.

However:

- Most patients said they were getting a good service from staff and that staff helped them with their care and treatment and most carers agreed. Patients were encouraged to give feedback on the service and to influence it.
- Staff were respectful and caring towards patients during their interactions, and they had a good understanding of patients' needs.
- Staff were proud of their work and had good morale. Staff said they worked well in their multidisciplinary teams. They said they were supported in their role and had opportunities to learn and develop relevant skills for their work.
- The provider had increased the number of female staff working on Yellowwood and Cherry wards and had increased their staffing establishment across the wards. They contracted locum staff to ensure consistency of care for patients and address staffing shortfalls.
- Staff had developed a restrictive practices group to reduce blanket rules for patients occurring in the hospital. Staff completed comprehensive assessments and care plans for patients.
- A speech and language therapist developed communication plans for patients which the provider checked to ensure they met best practice standards.
- The hospital had a range of facilities. Staff gave examples of how they supported patients' diverse needs.
- The provider had a range of governance systems to assess and monitor the quality of the service involving staff, patients and others.
- The hospital met 87% of the quality network for forensic mental health services low secure standards, which had increased since our last visit.

Summary of findings

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Summary of this inspection

Background to Oaktree Manor

The provider for this location is Partnerships in Care (Oaktree) Limited and the corporate provider is Arcadia. As of 01 December 2016 there had been changes to the corporate provider as Partnerships in Care and Priory Healthcare Limited had merged organisations.

Oaktree Manor has six low secure wards with 47 beds and offers inpatient care and treatment for people with a diagnosed learning disability, autism and mental health needs.

Oaktree Manor has been registered with CQC since 13 December 2010. This location is registered to provide the following regulated activities: diagnostic and screening procedures; assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

The low secure wards at Oaktree Manor admit patients with a primary diagnosis of learning disabilities:

- Cherry and Yellowwood wards – for women with eight beds in Cherry ward and seven beds in Yellowwood ward
- Maple and Pine wards – for men with eight beds in each ward
- Rowan and Redwood forensic wards – for men with eight beds in each ward

There have been four inspections carried out at Oaktree Manor. The most recent was carried out on 21 to 22 October 2015. When we last inspected, we rated the location as 'good' overall and 'requires improvement' for safe. We told the provider they must make the following actions and issued a requirement notice for a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, Regulation 9, person centred care.

• The provider must ensure that Yellowwood and Cherry wards have adequate staffing levels including appropriate gender mix at all times.

The provider sent us a plan following the inspection detailing the actions they would take to address this. We checked on this at this inspection and found the provider had addressed the concern.

Since October 2015 there have been two visits by mental health reviewers.

Mrs Beatrice Nyamande is registered with the Care Quality Commission as the hospital manager and as the controlled drugs accountable officer.

Our inspection team

Our inspection team was led by:

Team leader: Karen Holland, Inspection manager, mental health hospitals

Lead Inspector: Kiran Williams, Inspector, mental health hospitals

The team included four CQC inspectors and an inspection manager.

The team would like to thank all those who met and spoke to inspectors during the inspection who were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the location.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme and also to find out whether Oaktree Manor had made improvements since our last comprehensive inspection in October 2015. This was an announced inspection.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients and staff at focus groups.

During the inspection visit, the inspection team:

- visited all six wards at the hospital and the Oaktree centre, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 29 patients who were using the service;
- spoke with seven carers of patients who were using the service;
- spoke with three directors including the registered manager and a consultant psychiatrist
- spoke with two clinical nurse managers and managers for each of the wards;
- spoke with 38 other staff members; including nursing staff, occupational therapist, physical health care lead, forensic psychologist, social worker and speech and language therapist;
- received feedback about the service from commissioners;
- spoke with an independent advocate and a pharmacist
- attended and observed an early morning review meeting and a multidisciplinary meeting;
- collected feedback from 22 patients using comment cards;
- looked at 22 care and treatment records of patients;
- looked at 22 prescription charts
- looked at 10 staff records;
- carried out a specific check of the medication management on wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We spoke with 29 patients who were using the service and seven carers. We received 22 comments cards from patients (46% of the patients).
- Thirteen patients stated in comments cards they received a good service from staff at the hospital.
- Nine patients' comments cards stated that staff were helpful and supportive. Eighteen patients told us this also. Other positive comments from patients included having staff support to maintain family contact. Two patients stated that staff were not supportive on Maple and Pine wards.
- Patients gave us mixed feedback stating they were asked their views for their care and treatment but some patients' forum representatives said they did not always get copies of their care plan.
- Twelve patients told us they did not feel safe and this was raised by several patients from the patients' forum. They gave us examples of times when restraint had been distressing. Four comments cards received from patients stated they felt safe on the wards.
- Patient forum representatives, four patients and three comments cards gave negative feedback about the food provided with comments regarding the quality and variety.
- Ten patients told us they wanted more meaningful activities. Some patients said there could be more weekend activities.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- The provider had not ensured that reviews of patients in seclusion took place as per their policy and the Mental Health Act 1983 code of practice. For example doctors did not always review patients within one hour of the seclusion starting as doctors were not based on site out of hours.
- The provider had difficulties recruiting permanent nursing and healthcare workers. Vacancies had significantly increased since our last inspection.
- The provider still had high and low-level ligature points across the hospital and lack of anti-barricade protection on some patient area doors which posed risks to patients with self-harming behaviours.
- Staff still could not easily observe patients on Rowan and Redwood ward due to ward layouts.
- The number of staff restraints of patients had increased since our last inspection and several patients told us they did not like restraints taking place on the wards.

However

- The provider had identified the risks for seclusion reviews and staffing recruitment on their risk register as a significant risk within the hospital which senior managers regularly reviewed. The provider monitored their use of seclusion and restraint with patients to identify areas for improvement. Staff had developed a restrictive practices group to reduce blanket rules for patients occurring in the hospital.
- The provider had increased the staffing establishment across the wards, including the number of female staff working on Yellowwood and Cherry wards. They were involving patients in the audit of this. They block contracted agency staff to work on the wards for several months at a time to ensure consistency of care for patients and ensure there were enough staff available.
- The provider had systems to report incidents and identify any themes for wards and patients and detail actions required. We saw examples of staff taking action to reduce risks following incidents and they completed comprehensive risk assessments of patients.
- Staff regularly completed environmental risk assessments to ensure the hospital was clean and safe.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Staff said they worked well in their multidisciplinary teams. They said they were supported in their role and had opportunities to learn and develop relevant skills for their work.
- Staff provided a range of therapeutic interventions in line with national institute for health and care excellence guidelines which patients said was helping them.
- A speech and language therapist was in post and had developed communication plans for patients which the provider checked to ensure they met best practice standards.
- Staff supported patients to access physical health checks in both the hospital and community as required. Staff had developed health action passports for patients as an easy reference guide.
- Staff knew how to contact the Mental Health Act office for specialist advice when required. The provider had reviewed their processes for monitoring the Mental Health Act 1983 documentation following an incident.
- Staff reviewed patients' mental capacity to make decisions regarding their care and treatment on a regular basis.

However

- Staff held patient records in paper and electronic files. Staff did not consistently file records where expected and had difficulty finding documents for example relating to physical health checks, long term segregation and mental capacity act assessments. This posed a risk that staff would not have easy access to relevant information. Following the merger, five patients' positive behavioural support plans were deleted from a shared computer drive which meant staff had to develop them again.

Are services caring?

Good

We rated caring as **good** because:

- We observed staff being respectful and caring towards patients during their interactions, offering support when they were distressed.
- Staff showed they had a good understanding of patients' needs and gave examples of how they supported patients.
- Nine comments cards received from patients stated that staff were helpful and supportive. Eighteen patients also told us this. Carers were positive about the kindness and support staff gave to patients and them.

Summary of this inspection

- The hospital had an identified dignity champion and carried out checks to see how they could improve their care of patients.
- The provider had a range of paper files and documents where patients' views were recorded such as positive behaviour plans. Patients could keep these folders in their rooms. Staff encouraged patients to give their views on their care, for example at multidisciplinary meetings.

However

- The provider's electronic care and treatment documents did not easily capture patients' views on their care. Some patients' forum representatives said they were asked their views for the care and treatment but they did not always get copies of their care plan.
- Four carers said that staff did not always keep them informed about changes to the patients care.

Are services responsive?

Requires improvement

We rated responsiveness as **requires improvement** because:

- The provider had challenges with moving patients out of the hospital which meant that some patients were in hospital for a long time.
- The average length of stay for patients (now discharged) was 826 days, significantly longer than the national average of 554 days. Pine ward's average length of stay for patients was the highest with 1410 days.
- Several patients told us they did not like the food and there was not enough variety. They said they wanted more meaningful activities.
- Staff had not adequately set up multi faith rooms on Redwood, Rowan, Maple and Pine wards.
- Patients' forum representatives said they did not always think complaints investigations were thorough enough.

However

- Staff invited commissioners and community teams to care programme approach meetings and care and treatment reviews took place.
- The provider offered patients a range of ways they could give feedback on the service to influence it. These included meetings and patients being involved in staff recruitment interviews and meeting new staff at inductions. The provider offered patients monthly food tasting opportunities to improve the menu offered.

Summary of this inspection

- The hospital had a range of facilities including areas for horticultural and animal husbandry and rooms for adult education with computer access.
- Staff offered patients a minimum of 25 hours therapeutic activity and had systems to monitor this was provided.
- Staff gave examples of how they supported patients' diverse needs such as arranging for cultural food, hairdressers and spiritual support.

Are services well-led?

Good

We rated well led as **good** because:

- Most patients said they were getting a good service.
- Staff were proud of their work and had good morale. They said their managers were effective and approachable and they kept them updated about issues and incidents relevant for their work. Managers gave examples of how they supported staff such as having flexible working arrangements. The hospital's rate for staff sickness was lower than the national average.
- Managers had professional development time and leadership opportunities and gave examples of team building events.
- The provider had a range of governance systems in place to assess and monitor the quality of the service involving staff, patients and others.
- The hospital met 87% of the quality network for forensic mental health services low secure standards, which had increased since our last visit.

However

- Manager's oversight of staff's review of patients placed in seclusion was not effective as the provider's policy and Mental Health Act 1983 code of practice was not being consistently followed.
- The provider's staff survey 2016 identified staff were less satisfied with the way provider, partnerships in care engaged with staff.
- The provider had difficulty retaining staff and turnover was still high as staff were leaving to join agencies because of increased wages.
- The provider had identified they had not developed their systems to address the workforce race equality standards.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- All patients were detained under the Mental Health Act 1983 except one who was due to be discharged. Some were detained under Part III of the Act due to having committed a criminal offence.
- The provider had systems in place to check documents relating to patients detention under the Mental Health Act 1983. The provider notified us of an incident where staff had made an error in this process. They told us of actions they had taken to reduce the risk of reoccurrence.
- Staff were enabled to meet their responsibilities under the Mental Health Act through training, policies and procedures. As of January 2017, 94% of staff had completed Mental Health Act 1983 training.
- The provider had systems, processes and practices in place to make sure that patients' rights were protected. Although patients' forum representatives said they had not been reminded of their legal rights recently.
- Staff knew how to contact the Mental Health Act office for advice when needed and gave us positive feedback about the support they got from the administrator. The Mental Health Act team undertook checks of section 17 community leave and section 58 consent to treatment documentation. However, a consent to treatment form 'T2' was not available in the patient's records. Staff later found this.
- Staff showed us examples of assessments completed for patients before and after they had taken section 17 Mental Health Act community leave. Patients' forum representatives told us they got access to community leave.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety four percent of staff had completed training for the Mental Capacity Act 2005 and most staff we spoke with had an understanding of the principles.
- The multidisciplinary team reviewed patients' capacity to make decisions at individual care review meetings. We asked staff if they could show us examples of specific assessments they had completed where a patient's capacity to make a decision was in doubt. However, staff had difficulty finding this information to show us on site. We had raised this as an issue at our last inspection.
- The social worker told us that most patients had appointeeship arrangements for others to manage their statutory benefits and the social worker was involved in assessments when patients were moving on from the hospital.
- The speech and language therapist told us they were often involved in assessment for patients supporting them to communicate their wishes and wants.
- No patients were subject to a Deprivation of Liberty Safeguards application during our visit.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- The hospital was not purpose built and ward layouts did not always allow staff to easily observe patients. 'Blind spots' were identified for Rowan, Maple and Pine wards and mirrors were in place to aid staff's observation of the ward.
- Maple and Rowan ward nursing offices were not central on the ward and staff could only observe parts of the corridor. On Rowan ward, staff completed specific area observations. This meant there was a staff member in each of the ward areas to reduce the risks.
- At both our last inspection and this one we found that high level ligature points such as door closers were across wards in communal hall areas. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Low level points included taps in communal bathrooms, kitchen and laundry areas which had restricted patient access. Patients were risk assessed prior to having unsupervised access to the bathrooms. Patients had ensuite shower rooms. The provider had ligature assessments and had assessed high risk ward areas as needing to be managed by staff with use of observations and individual risk assessments for patients. Since our last visit the provider had developed posters identifying high risk areas to improve staffs' awareness. Patients had access to media devices and cables which could present a ligature risk. Staff had completed individual ligature risk assessments for patients with self-harming behaviours.
- The last quality network peer review had also commented on difficulties with lines of sight particularly on Rowan ward and they had observed ligature points.
- Not all wards had doors that could be easily opened if a patient barricaded themselves in the room, for example Cherry ward's bathroom. Staff said they risk assessed patients access to rooms without these doors and that no incidents with doors had recently occurred. Safety plastic was placed as an additional measure to strengthen some fire exit doors such as on Cherry ward.
- Wards shared fully equipped clinic rooms with accessible emergency equipment and medication which were regularly checked. Staff were replacing Rowan and Cherry ward medication fridges which had broken and were not in use.
- There were three seclusion rooms on Rowan, Yellowwood and Maple wards which other ward staff could access for patients. The seclusion room on Rowan ward was being refurbished and temporarily not in use. There were interim measures to use other areas or Pine wards seclusion room in case seclusion was required. However, Rowan and Redwood wards had a lower use of seclusion than others.
- Ward and hospital environmental risk assessments took place. These included checks for sharp objects, fire safety checks and fire drills.
- Staff completed daily infection control checklists and the provider had rotas for cleaning to ensure a clean environment. An occupational therapist told us they completed checks which included labelled fridge items.

However, on Cherry ward staff had not labelled food items in the patients' fridge which could pose a risk that items were left open beyond the manufacturers recommended time.

- Staff and visitors were given safety alarms. Patients' bedrooms had alarms to summon staff assistance. We heard these being used and tested a patients alarm on Cherry ward.

Safe staffing

- The nursing establishment for the hospital was 30.6 whole time equivalent (wte) nurses and 71.7 wte healthcare workers. There were five bank staff (employed by the provider as and when required to cover staff shortfalls).
- The provider had increased their staffing since our last inspection. They had identified that Yellowwood and Cherry wards required seven nursing staff planned for the day and six staff at night. Maple and Pine ward required eight nursing staff planned for the day and six staff at night. Redwood and Rowan required six nursing staff planned for the day and five staff at night. Staff worked long days with 12 hour 15 minute shifts. Additionally managers had arranged 'twilight' shorter evening nursing shifts for busier times when patients needed more support. Managers attended daily early morning review meetings and weekly resource meetings to review staffing needs.
- Since our last inspection, the provider had significantly more staffing vacancies at this hospital. There were 20.01 nurse and 24.1 healthcare worker vacancies across the hospital (we reported in 2015 that this was 12.14 nurses and 6.84 healthcare workers. The provider had made four nursing and healthcare worker recent offers of employment to people. Hospital directors said that recruitment was a challenge and on their risk register. A director said there were 67% nurse vacancies 40% of these were filled with locum nurses.
- Following our last inspection the provider sent us an action plan for Yellowwood and Cherry wards to have adequate staffing levels including appropriate gender mix at all times. They had recruited six female healthcare workers and had 64% female staff. The provider had set an 80% ratio of female staff and the patient forum were carrying out an audit with staff to check on this. Latest information from the provider stated that 74% of staff on Yellowwood and Cherry wards were female, slightly below the provider's standard but a significant increase since our last inspection. They stated they had an on-going recruitment drive.
- Staff did not report any challenges with staffing. However, information from the provider showed in August and September there were 43 occasions and 41 in October 2016 where staffing was below the required establishment. Latest safer staffing information from the provider for October to December 2016 showed 99% of staff shifts were met with 0.8% not meeting planned requirements but not at unsafe levels. The provider sent us information showing there were no unfilled nursing shifts from October to December 2016.
- Two managers told us that shifts were not unfilled. However, there were some shifts which were partially covered, for example staff worked later or earlier to cover part of the shift if there was staff sickness. The ward manager, who was not involved in the nursing establishment, also could work shifts. One carer told us that a home leave trip to celebrate a special event was recently cancelled due to a lack of staffing.
- Across wards there were regular bank and agency staff used. Managers said they were using block contracts for 'locum' agency staff to aid consistency of care. For October 2016 there was 5,429 hours used.
- Information from the provider showed that 65% of nurses employed had a learning disability qualification. Managers said this was a challenge as fewer universities were training learning disability nurses.
- Managers and directors told us how the provider was encouraging recruitment, for example a banner was displayed outside the hospital. Staff attended recruitment days at local universities. Managers reviewed their recruitment weekly. They said the challenge was a national issue and said that nurses often preferred to work for agencies as the pay was more competitive, they could choose shifts and could cancel shifts more easily.
- The provider employed two full time consultant psychiatrists and an associate specialist doctor. Wards had an allocated consultant psychiatrist. The provider covered out of areas medical cover with their own consultants, a consultant from another provider hospital and two contracted doctors. There was no out of hour's medical cover on site. Two of the on call doctors lived some distance away from the hospital. However, staff told us they could respond within an

hour. On one occasion the on call doctor was not contactable by staff and the consultant was called to attend the hospital. The clinical director said this was a rare occurrence. They had previously requested another doctor as a lower grade but this was not currently approved.

- Staff mandatory training compliance overall for 09 January 2017 was 95%, above the providers target of 90%. This had increased since our last inspection with 96% of permanent and 86% of bank staff completed training. Maple and Pine wards compliance was not achieved for four training courses, Yellowwood and Cherry wards had not achieved three and Redwood and Rowan wards had not met one. The lowest compliance was Maple and Pine wards with 50% training compliance for immediate life support and 54% training compliance for basic life skills on Yellowwood and Cherry wards.

Assessing and managing risk to patients and staff

- The provider sent us information about the number of times staff had used restraint with patients or had placed them in seclusion. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.
- This showed an increase compared with our 2015 inspection. Staff told us that these did not mean that all patients required this. The provider stated that patients can have seriously challenging and aggressive behaviour. They gave us an explanation of the reasons for restraint. For example staff identified August and December 2016 as peak times when some patients had been unsettled. The provider had systems for tracking individual patient's incidents and identifying themes. Staff told us chain or functional analysis took place to assist to decrease incidents.
- Data from the provider from April to October 2016 showed 138 incidents of seclusion and three incidents of long term segregation of patients. The highest was Yellowwood ward with 102 seclusions and two episodes of long term segregation; then Pine ward with 25 seclusions and one episode of long term segregation. The lowest was zero for Rowan ward and two seclusions on Redwood ward. Information from October to December 2016 showed 66 occasions where a patient was placed in seclusion.
- We reviewed a sample of seclusion records and found 11 where either a medical review or nursing review had not taken place as per the provider's policy. For another record there was a delay in notifying the doctor to attend to review and they were contacted when seclusion ended (less than an hour). Another record did not have the date and time of the two hourly nursing review. We met with senior staff about this. They showed us the last audit they had completed for March to August 2016 and stated that most seclusion records were checked daily for quality at multidisciplinary early morning review meetings. Managers had recorded delays in doctors attending seclusion reviews on their risk register. A director and a manager confirmed there had been breaches of doctors attending reviews within an hour as identified in the Mental Health Act 1983 code of practice. On an incident report, staff had recorded they had 'asked' a patient to go to the seclusion room. A manager told us that staff sometimes used this as a low stimulus area for patients but it was not recommended.
- Information from the provider from April to October 2016 showed 959 incidents of staff restraining patients with the highest for Pine ward with 428 with seven in prone position and five incidents of staff giving rapid tranquilisation injections. Yellowwood ward had 341 restraints with 14 in prone position for staff to give rapid tranquilisation. The lowest was Rowan ward with 20 restraints, four of them in prone position and three incidents of rapid tranquilisation. Information from October to December 2016 showed 447 restraints.
- Staff said patients would be put into the prone position in order to administer urgent intra-muscular injections. Prone position restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Staff said they were trained to use prone restraint only when absolutely necessary, for the shortest possible period and were working towards reducing the use of restraint as recommended in the guidelines 'Positive and proactive care' produced by the Department of Health in 2014. A director told us that a process for teaching staff to use a different holding techniques when administering injections, whilst patients are under restraint was being reviewed.

- We reviewed a sample of restraint records and one stated that a patient on Yellowwood ward was given emergency medication by injection. This was not recorded as prone restraint when a manager said it should have been. Other records gave detail of the reason for restraint and showed staff used verbal de-escalation techniques with patients first. We observed staff restraining a patient using wrist holds in a communal area and using verbal de-escalation techniques. We saw examples of staff completing checks of patients' physical observations in records following staff giving rapid tranquilisation medication.
- Staff could refer to 'my positive behavioural support plans', management of aggression care plans and risk profiles completed by the psychology team to reduce patient incidents. However, due to technical difficulties five women's positive behavioural support plans were lost and psychologists and patients were in the process of developing them again. A manager said the positive behavioural support plans changed in June 2016 and staff had training for the revisions in October and November 2016. A manager said that dialectical behavioural therapy had reduced female patients needing additional medication and restraint and gave examples of this.
- Ninety eight percent of staff had completed 'breakaway, conflict resolution MVA' (management of violence and aggression) training. Locum staff were also offered management of violence and aggression training.
- Patients had individualised risk assessments and these had been reviewed by the multidisciplinary team. Risk assessments took into account historic risks and identified where additional support was required.
- Staff used various risk assessment tools including the short-term assessment of risk and treatability (START), health of the nation outcome scales (HoNOS) and the historical clinical risk (HCR 20) as part of their initial and on-going assessment of risk.
- Staff had developed a restrictive practices group where patients and staff met to review and reduce blanket rules occurring for patients in the hospital. Patients and staff had developed a range of posters for example to remind staff that 'supportive not restrictive' practice was emphasised.
- Twelve patients told us they did not feel safe and this was raised by several patients from the patients' forum. They gave us examples when restraint had been distressing. They said more staff should be on duty. The provider said they would take action to investigate this and would update us on the issues. Four comments cards received from patients stated they felt safe on the wards. A carer told us their relative had been hit on the ward despite staff being with them.
- Managers had systems for tracking and monitoring safeguarding referrals. Staff were aware of their individual responsibility in identifying any individual safeguarding concerns, reporting these promptly and ensuring protection plans were in place for patients. Staff displayed leaflets promoting anti bullying. Some patients were aware that incidents were reported to the police but said they had not got further feedback. The provider held monthly meetings to review reported safeguarding incidents and investigations and invited the local authority and police. The provider had systems in place for assessing and approving requests for child visits. These visits took place off the ward.
- There were systems in place for safe storage and management of medications. This included fortnightly visits by an independent pharmacist to audit the medications being used.
- The physical health lead carried out monthly emergency physical health incident tests with staff, to practice and develop their responses in the event they were called to deal with an emergency.

Track record on safety

- A manager told us there were 12 serious incidents in the last 12 months. These incidents included patients' violence and aggression, absconsion, self-harming and injury and allegations of abuse.
- The provider had identified two 'never' events for 2016, which they had reported to commissioners and the CQC. Never events are serious incidents that are preventable as guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. However, whilst the events were serious incidents which could have been avoidable one clearly did not meet the latest criteria for reporting to NHS England.

Reporting incidents and learning from when things go wrong

- Information from the provider showed from October to December 2016 there were 721 reported incidents.
- There was an effective way to capture incidents and near misses. Incidents were reported via an electronic

incident reporting form. Most staff knew how to report incidents and were encouraged to use the reporting system. Staff told us that incidents would be discussed at senior nurse/staff meetings or in ward handovers. Ward to board reports tracked themes for the hospital and compared them with other provider hospitals. For example in August 2016, 235 incidents related to two patients. A director said the provider was reviewing the incidents reporting and review process to include the 'situation, background, assessment and recommendation' (SBAR). This is a nationally recognised communication tool designed to support staff sharing clear, concise and focused information.

- There was a governance framework which encouraged staff to report incidents. Incidents reviewed during our visit showed that investigations and analysis took place, with actions for staff and sharing within the team such as monthly newsletters, emails and debriefs.
- Staff gave examples of learning from incidents such as taking action to replace ward windows to ensure they did not open onto open areas following an incident on Pine ward in July 2016. The last quality network peer review March 2016 had also commented that windows needed replacing because they opened onto to unrestricted gardens. This presented a risk that restricted items could be passed through windows from outside of the hospital. The provider was completing this work during our inspection.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed records relating to approximately 22 patients' treatment and care.
- Staff carried out preadmission assessments before admission. Patients received a comprehensive and timely assessment after their admission.
- Staff completed physical healthcare examinations for patients. There was evidence of patients receiving ongoing monitoring of physical health needs. The provider employed a part time physical healthcare lead and a local GP visited regularly for appointments. Patients had health action passports However, some records were not updated. Staff had not recorded they undertook regular blood glucose monitoring checks for a patient on Cherry ward. A manager explained there were several places where this information could be recorded and they had encouraged staff to improve their record keeping.
- The provider had recently employed a part time speech and language therapist. We saw examples where they assessed patients' communication needs using nationally recognised assessments such as the Renfrew action picture test and care plans and communication passports were in place to meet their needs. The speech and language therapist said that outcome measures were being used. However, they considered it was too early to identify any improvements. The provider had audited communication support plans in 2016 to ensure they met best practice standards.
- Staff used electronic records and some paper records and we had difficulties locating information at times during our visit. For example, long term segregation review notes for a patient were recorded in two places on the electronic record. Staff later told us that there were two episodes of segregation and not one. The manager and doctor said reviews would be in the notes section. There was no record of the review for the previous day despite a staff member and the care plan stating reviews would be daily. However, no staff reported records access as a concern. Staff monitored patients' progress in multidisciplinary records and teams recorded data on progress towards agreed goals.
- Staff told us some electronic records on a shared staff records drive were lost following information technology issues and also the merger between two providers. They told us of how they were overcoming this challenge.

Best practice in treatment and care

- Staff completed a range of audits. For example, the pharmacist completed audits to ensure staff followed national institute for health and care excellence guidance when prescribing medication.
- Staff provided a range of therapeutic interventions in line with national institute for health and care excellence guidelines such as dialectical behavioural

therapy and cognitive analytical therapy and offence related work. Staff referenced national institute for health and care excellence guidance in patients care plans.
- Staff supported patients to access the local acute hospital for treatment and appointments as relevant.
- Staff used nationally recognised assessment tools, including the 'early warning score' assessment tool and the Lester tool. The Lester tool is a guide for health workers to assess the cardio metabolic health of people experiencing psychosis and schizophrenia.
- Staff referred patients for opticians, podiatrist and dentist appointments as relevant. The physical health nurse was liaising with NHS England to identify an appropriate dentist.
- Staff monitored patients weight and offered advice on healthy eating. Two carers said their relative had gained a lot of weight and were not sure that staff were fully addressing their physical health care needs.
- The hospital had become no smoking since August 2016 in line with NHS England guidance and staff offered patients smoking cessation support. One patient gave feedback on a comment card they were unhappy at not being able to smoke.

Skilled staff to deliver care

- Wards had multidisciplinary teams including nurses, healthcare support workers, doctors, psychology and therapy staff, occupational therapy staff, and a social worker.
- A manager told us that staff were recruited for the hospital and not specific wards. However, once appointed they would be matched to the ward according to their skill set and gave an example of this.
- New staff had an induction programme prior to working on the wards and nurses had a 12 week induction and for newly qualified nurses could access preceptorship. Managers said that locum staff were offered training prior to being booked to work shifts.
- Staff said that due to their break system, six hours a month was accrued and used for staff meetings and training. They gave examples of other specialist training offered such as for dialectical behavioural therapy and sensory integration. Managers referred to opportunities for support workers to complete the care certificate. This is a national certificate to provide staff with the skills and competencies to do their job. Doctors had bi monthly continuing professional development sessions (within the hospital and external).
- Staff told us they had opportunities to develop their roles for example, in learning dialectical behavioural therapy and supporting patients. Staff told us they valued the training offered by the organisation, in particular from the psychologist.
- The provider had developed a range of workbooks for staff to work through to develop their skills such as 'communicating with people in our care'. Staff received 'introduction to learning disability and autism spectrum disorder' training.
- Managers referred to systems in place to check staff competency such as a four week standard for receiving supervision and staff receiving annual appraisals. Information from the provider showed there was 90% overall compliance of staff supervision in January 2017 and we saw examples of this. Some staff had not received supervision as per the provider's standard for example due to having annual or sick leave. Managers achieved 97% overall compliance with staff appraisals which was within the provider's target. The nursing team as the largest and lowest group with 86% other disciplines were 100%. Staff meetings took place on wards with standard agendas to cascade information to staff. Some staff on Redwood and Rowan wards said they had reflective practice sessions with peers.
- The occupational and speech and language therapists told us they could also access professional supervision external to the hospital.

Multidisciplinary and inter-agency team work

- Regular nursing staff handovers and multidisciplinary team meetings took place. Handover information was shared between wards and teams in the early morning review meeting. The occupational therapy staff had developed a strategy to help raise the profile of their work and encourage greater multidisciplinary team working.
- Staff told us they worked well with the locum staff (block booked from agencies) and they were an integrated part of the team.

Requires improvement

Wards for people with learning disabilities or autism

- Staff worked with external agencies, such as with commissioners, community mental health and learning disability teams, ministry of justice, police and local authority. This included liaison with multi-agency public protection arrangements.

Adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice

- All patients were detained under the Mental Health Act 1983 except one who was due to be discharged. Some were detained under Part III of the Act due to having committed a criminal offence.
- The provider had systems in place to check documents relating to patients detention under the Mental Health Act 1983. The provider notified us of an incident where staff had made an error in this process. They told us of actions they had taken to reduce the risk of reoccurrence.
- Staff were enabled to meet their responsibilities under the Mental Health Act through training, policies and procedures. As of January 2017, 94% of staff had completed Mental Health Act 1983 training.
- The provider had systems, processes and practices in place to make sure those patients' rights were protected. Although patients' forum representatives said they had not been reminded of their legal rights recently.
- Staff knew how to contact the Mental Health Act office for advice when needed and gave us positive feedback about the support they got from the administrator. The Mental Health Act team undertook checks of section 17 community leave and section 58 consent to treatment documentation. However, a consent to treatment form 'T2' was not available in the patient's record. Staff later found this.
- Staff showed us examples of assessments completed for patients before and after they had taken section 17 Mental Health Act community leave. Patients forum representatives told us they got access to community leave.

Good practice in applying the Mental Capacity Act 2005

- Ninety four percent of staff had completed training for the Mental Capacity Act 2005 and most staff we spoke with had an understanding of the principles.
- The multidisciplinary team reviewed patients' capacity to make decisions at individual care review meetings. We asked staff if they could show us examples of specific assessments they had completed where a patient's capacity to make a decision was in doubt. However staff had difficulty finding this information to show us on site and we had raised this as an issue at our last inspection.
- The social worker told us that most patients had appointeeship arrangements for others to manage their statutory benefits and they were involved in assessments when patients were moving on from the hospital.
- The speech and language therapist told us they were often involved in assessments for patients, supporting them to communicate their wishes and wants.
- No patients were subject to a Deprivation of Liberty Safeguards application during our visit.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed staff being respectful and caring towards patients during their interactions, offering support when they were distressed.
- Staff showed they had a good understanding of patients' needs. They gave various examples of how they supported patients, for example support offering bereavement counselling and supporting patient with anniversaries. They told us how they could recognise triggers for patients when they were becoming upset and knew when to give additional support. Staff had developed, 'coping in crisis' workbook for patients to work though when they were in distress relating to using dialectical behavioural therapy techniques.
- We received 22 comments cards from patients (46% of the patients). Nine of these stated that staff were helpful and supportive. Eighteen patients told us this also. Other positive comments from patients included having staff support to maintain family contact. Two patients stated that staff were not supportive on Maple and Pine wards.
- Two carers were positive about the kindness and support staff gave to patients and them.
- The hospital had an identified dignity champion and staff had displayed posters to remind staff to treat

patients with dignity. The provider had completed a 'dignity in everyday life' audit in 2016 with 100% compliance against standards set and they had developed an action plan for further improvements.

The involvement of people in the care they receive

- We found various examples of how patients were involved in influencing their care and treatment or the service at the hospital. We saw examples of patients involvement in their positive behaviour support plans, 'one to one' plans and 'my shared pathway' recovery tools detailing patients' views and assessments of their needs, for example in patient's folders on Yellowwood, Rowan and Redwood wards. This was mainly in paper records and patients could keep these folders in their rooms. The electronic patient record for example on Maple on Pine wards did not capture the patients' views, often with statements that the patient agreed with their care plan and were given a copy. The electronic record was not patient centred in the design or easily readable.
- Patients gave us mixed feedback stating they were asked their views for the care and treatment but some patients' forum representatives said they did not always get copies of their care plan. We saw the provider had a system in place to monitor this.
- Staff discussed at the early morning meeting if carers had been contacted following incidents that took place with patients.
- Three carers said staff were helpful, they were involved in the patient's care and staff kept them updated on issues. Four carers told us that staff did not always keep them informed about changes to the patient's care For example staff did not always give them information about medication changes and side effects. However, they said that staff knew the patients' needs. A carer said they were not involved in care planning.
- Patients could proactively chair their care programme approach (CPA) meetings so they were actively involved in talking about their care and treatment needs and making decisions or ward community meetings where they could raise issues with staff and encourage other patients to. We observed that staff supported patients with their communication skills by encouraging them to bring a list of things they wanted to discuss at multidisciplinary meetings.
- Newly admitted patients had a 'buddy' to help orientate and welcome them to the ward.
- Patients had access to advocacy services and information regarding these services was displayed across wards. This included access to independent mental health and independent mental capacity advocates.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- The average bed occupancy from May 2015 to November 2016 was 98%. Most wards had 100% occupancy except Rowan ward which had 87%. This is higher than the average (85%) recommended for adult in-patient mental healthcare. However, admissions were planned in advance. Following a referral staff carried out assessments. The hospital currently did not have a waiting list.
- Care pathways and admissions could be from high secure units, secure units, prison, courts or other inpatient units. Patients were placed from various parts of the United Kingdom or Ireland due to placements not being available in their home area to meet their needs.
- Information from the provider stated that patients were often in hospital for a long time. The average length of stay patients for discharged patients was 826 days. This was above the national median average (554 days). The highest length of stay for patients was for Pine ward with 1410 days and the lowest was Maple ward with 420 days. Staff told us that this was because many patients had complex care and treatment needs such as on the wards for patients with Autistic spectrum disorder.
- From May 2015 to November 2016, there were seven delayed discharges.
- Staff told us one of their biggest challenges was discharging patients from the hospital to less secure care. Staff said this was because suitable less secure placements were not available or there were issues with funding which was beyond their control. Staff said they worked with the home area community teams to ensure that patients who had been admitted were identified and helped through their discharge. Discharges or

transfers were discussed in the multidisciplinary meeting and were managed in a planned or co-ordinated way. The responsibility to identify and fund placements was the patients' home area local commissioners. Care programme approach and care and treatment reviews took place with commissioners and community teams.

- Staff showed us discharge plans that NHS England recommended staff complete with patients to help with support them with planning towards discharge. However we did not see any completed and staff said these had been available for a few months. Some patients said they were aware of the document.The provider clarified that only patients with imminent placements were issued with the NHS England Discharge packs as NHS England did not have enough to issue all patients.
- Patient forum representatives gave us mixed feedback about being supported for discharge. Several staff spoke of challenges with discharging patients. They told us patients often had difficulty understanding the reasons for the delay and had become frustrated with the process. Three carers said they would like their relative to be placed nearer to them. However, the provider clarified they had supported and advocated for patients to be moved nearer their families.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider offered patients a range of ways they could give feedback on the service to influence it. These included, ward meetings, being involved in interviews, monthly patient forums and meeting new staff at inductions.
- Wards were mostly well equipped to support patients' treatment and care. There were rooms where patients could relax and watch television or engage in therapeutic activities. These included quiet areas, activity and meeting rooms, sports areas and secure courtyard areas. Yellowwood ward had a sensory room and equipment.
- The 'Oaktree centre' had a horticultural area, animal care, library, outside gym, social area and designated dialectical behavioural therapy room. The provider's patient education courses had approved ASDAN (a national charity) programmes and qualifications that grow patient's skills for learning, employment and for life. Staff and patients gave examples of vocational work opportunities within the hospital and in the community. Patients could also access some community leisure and social clubs. One patient told us how staff were supporting them to go to a football match. Staff encouraged patients to submit their art for a Koestler award. This is a charity art awards scheme for offenders, secure patients and detainees.

- Staff told us that there was a programme of works to ensure patients were involved in choosing the decoration of rooms. Patients could personalise their bedrooms, for example, they displayed pictures or posters and had their own duvet covers. However some rooms, for example, on Yellowwood ward had damaged paintwork and ceilings which staff said maintenance staff were repairing. We found rooms where paint had been damaged due to posters being removed. One patient's room had marked flooring. Staff said cleaning staff were unable to remove the mark and staff were buying a rug chosen by the patient to cover it. Staff told us they could easily report issues to the maintenance team and they responded quickly. We saw examples of this. A patient told us on Cherry ward that one light was not working for approximately a year. We saw it had a sticker stating it was faulty. Staff contacted maintenance staff to address this during our visit.

- There were designated quiet rooms and areas for visitors to meet patients. Most carers were satisfied with arrangements. Staff at the staff forum said there was a lack of quiet rooms for one to one work with patients.
- Patients had private telephone access. We saw examples of individual care plans for patients' contact with families and friends.
- Staff and patients told us drinks and snacks were available on wards. We saw water dispensers on wards yet patients did not have easy access and had to ask staff for a cup. Patients had opportunities to practice and develop their daily living skills, such as cooking, shopping, budgeting and washing laundry. Ward kitchens were locked and patients had access if their risk assessment showed low risks, otherwise they had to request staff to give them drinks or snacks.
- Patient forum representatives, four patients and three comments cards gave negative feedback about the food provided with comments regarding the quality and variety. The provider had a range of ways they gained feedback from patients, such as comments books, community and patient forum meetings, surveys and

monthly food tasting. Staff asked patients daily for their choice of meal. Staff had free meals and said that overall the food quality was good with variety. However, they told us there was little flexibility on menu choices on the day such as if a patient wanted to change their choice they only had a cold option (sandwich or salad). One carer said their relative did not like the food offered. Another said that sometimes their relative did not like the food.

- At our last inspection, the provider was changing the main meal to evening instead of lunchtime at the patients' request. This had required getting additional lighting to ensure staff safety when transporting food across to the wards in the evening. However, this was not in place. Managers said this was because of the mixed feedback from patients but it was due to start in January 2017.
- Patients had risk assessments for access to bedroom keys and had furniture that was lockable. A manager and patients told us that staff would lock the furniture if there were risks identified, for example accessing items which could pose a risk to them. Patients did not have their own keys to lock their possessions safely in furniture despite the 'baseline restrictive practice audit action plan' (July 2015) identifying this as an action.
- The provider monitored patients' access to ensure patients were offered a minimum of 25 hours a week therapeutic activity. Information from the provider showed 70% of patients attended sessions and 30% of sessions where patients declined to attend in November 2016. Ten patients told us they wanted more meaningful activities. Some patients said there could be more weekend activities. Four carers said their relative was offered a range of activities. Occupational therapy staff told us they met with patients to gain feedback on their interests and needs and patients had individual timetables. Men and women usually had separate sessions. However, there are some mixed sessions (risk assessed and carefully planned). The provider employed two occupational therapists with one vacancy which staff said impacted on the delivery of their service. A manager said they had difficulties recruiting and were planning to use agency staff in the interim. A staff member said the occupational therapy service was provided seven days a week with nursing staff also supporting patients with activities.

Meeting the needs of all people who use the service

- Wards were on ground level and were accessible for patients with mobility difficulties.
- Staff gave examples of how they met patients' cultural, language and religious needs. The provider had ensured that patients had a range of easy read pictorial leaflets and information available to meet the accessible information standard, for example on medication. Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment when needed. The speech and language therapist had level one Makaton and British sign language training to assist patients with communication needs. Staff gave examples of supporting or encouraging patients to use where relevant hearing aids.
- The provider had a five week menu which included Halal and Caribbean meal choices. We noted vegetarian main meal options often contained a branded meat substitute. However, no patients raised this with us as an issue. On two days there was only one light vegetarian meal choice which meant that vegetarian patients could have limited choices.
- There were several multi faith rooms which could be accessed on the hospital site. However, these were not set up for on the men's wards with limited furnishings or information. Local faith representatives visited the wards as required and could be contacted to request a visit.
- Staff supported patients to access afro Caribbean hairdressers and products.
- We asked a sample of managers how they met lesbian, gay, bisexual and transgender patients' needs. Managers said staff would support them but gave limited details. A patient told us there should be a way of meeting their sexual needs. Two other patients told us they wanted more support from staff with their relationships.
- The provider stated that staff gave gender sensitive care. This included personal care supported by staff members of the same sex, access to a female GP and access to gender specific clinics such as hormone treatment and cervical smear tests. A men's health group was available.
- Patients told us they could access support to manage drug and alcohol issues. Psychology staff said they held drop in sessions for Rowan and Redwood patients to meet with them.
- Yellowwood and Cherry ward staff told us they had a designated lead for arranging contact and leave with

patients' families and carers, which gave patients and carers a familiar contact and consistency. The provider stated they held an annual carers day and had a dedicated contact day.

Listening to and learning from concerns and complaints

- There were systems for processing, monitoring and responding to complaints and we saw evidence of this. Staff told us that any learning from complaints was shared with the staff team and we saw that feedback on complaints and safeguarding issues was a standard agenda item for the patients' forum meeting. Pictorial complaints information was available for patients. Staff had not clearly displayed this on Yellowwood and Cherry wards. However, patients knew how to raise concerns as we observed staff supporting a patient to make a complaint. Managers referred to opportunities for local resolution of complaints and also mediation. These were recorded in individual patient's records.
- Information from the provider for September 2015 to October 2016 showed nine complaints. Four of the complaints were partially upheld and none were referred to the Ombudsman. None were for the women's wards. Ten compliments were received.
- The provider carried out an annual audit of complaints. Latest results for 2016 were mostly positive as 65% of patients felt supported to raise a complaint, 76% were happy with the outcome and 71% received an acknowledgement in the expected timeframe. Improvements were identified for communicating with patients.
- Patients' forum representatives told us they did not always think the investigation was thorough enough.
- Admission and discharge questionnaires were offered for patients to give feedback. The provider carried out annual surveys to gain feedback from patients and family/friends with detailed action plans to respond to any identified issues.

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

Good

Vision and values

- Staff told us that the board of directors had changed since the merger. Senior staff had visited hospital sites to meet staff and staff had been told that until changes were made said it was "business as usual". Managers told us the new organisational visions and values were in the process of being redeveloped and were expected by March 2017.
- Staff referred to getting feedback about the changes via team meetings and newsletters. The regional director and hospital director had not changed. They were accessible to staff as they had offices at the hospital site.

Good governance

- Due to the changes existing hospital governance meetings were still in place such as a monthly managers meetings and weekly senior nurse resource meetings.
- There were systems in place to assess and monitor the quality of the service such as support and development of staff and staffing risks. Staff gave feedback on risks and good practice. We saw examples of meeting minutes where staff reviewing incidents and safeguarding issues as relevant for their ward. There were designated staff leading on issues for the hospital such as health and safety, clinical risk and these staff also attended regional meetings to give feedback. However, management oversight of staff's review of patients placed in seclusion was not effective as the provider's policy was not being followed consistently.
- The provider had governance processes in place to manage quality. Managers used these methods, such as completing monthly 'ward quality matters' documents with patients identifying differing themes for their area. The provider had a 'ward to board' tool they used to monitor quality across hospital sites. Managers had access to dashboards which tracked incidents and other relevant data for their ward and hospital.
- Managers told us they were meeting contracted targets set by commissioners.
- Staff completed other audits for example a primary nurse audit November 2016 showed 100% compliance against the standards set.
- Patients had opportunities to get involved in hospital governance for example via the restrictive practices group and 'have your say' meetings with the hospital director. Thirteen patients stated in comments cards they received a good service from staff at the hospital.

Leadership, morale and staff engagement

Requires improvement

Wards for people with learning disabilities or autism

- Staff told us they were proud of their work, there was good team morale and they felt supported by their managers and teams. They said they could approach their managers with any concerns or feedback and felt supported by them. There were out of hours on call rotas for senior nurses, managers and doctors who staff could contact to discuss issues with. Staff were aware of external confidential support helplines and whistleblowing processes. The provider displayed staff suggestion boxes for managers to give feedback and to respond to. The provider had a staff consultative committee which considered issues such as ensuring staff wellbeing. A staff member told us that staff's stress levels were high because staffing levels were not enough when patients were unsettled.
- Managers told us there was high retention of the management team since our last inspection. Information from the provider from September 2015 to October 2016 showed 25% staff turnover. Whilst still high this had decreased since our 2015 inspection. The average rate of staff sickness was 2.5% sickness which is lower than the national average.
- Exit interviews took place and a theme was detected that staff leave approximately 90% of the time to join agencies because of increased wages. This has been reported to us by other trusts and providers as a national issue.
- There were three ward managers across the six wards which were adjoined: Yellowwood and Cherry, Rowan and Redwood and Pine and Maple wards. Additionally there were other managers across all the wards and other teams.
- Managers had professional development time and leadership opportunities. Two staff told us there were limited opportunities for their career progression but were optimistic given the recent organisational changes.
- The provider carried out a hospital staff culture of care' survey' in 2016 before the merger. Positive feedback from staff included team working, support from colleagues and line managers, training and development and being able to influence the service. The provider had developed an action plan for areas with negative or neutral scores which included improving senior managers' engagement with the hospital, staff engagement with the organisation and improving the ratings for staff recommending the organising as a place to work and for treatment.
- A manager gave an example of team building events and arranging football matches.
- We asked managers and directors how the hospital was meeting workforce race equality standards with staff. The provider sent us their statement and action plan but this was not specific to this hospital. Following the inspection the provider sent a specific statement for the hospital. Information detailed that the provider was taking actions to be in a position to set up full reporting on October to December 2017. They had identified challenges as being not having accurate staff data and also as an independent healthcare provider their staff survey did not match with national NHS staff survey indicators. A quarterly staff consultative committee gave staff group representatives an opportunity to discuss workforce matters directly with the senior management team.
- Managers gave us examples of how staff with diverse needs were supported. The hospital had an equality and diversity lead and 100% of staff had completed equality and diversity training as of October 2016. Arrangements were made for staff to have time off during religious festivals, for example staff could request to work a night shift during Ramadan. Agreements were made for staff to wear cultural headscarves. Managers said they supported staff with disabilities for example they had modified their training for staff with dyslexia to give extra time for training and more audio/visual methods.
- Managers told us how they supported staff with flexible shift patterns for example they had several staff who worked part time as healthcare workers as they were training to become nurses.
- The provider had a duty of candour policy. We saw an example where staff were open and transparent with a patient following a serious incident where they self-harmed and sustained an injury.
- There had been four incidents of staff sustaining an injury at work which met the threshold for reporting to the Health and Safety Executive.

Commitment to quality improvement and innovation

- The hospital were members of the quality network for forensic mental health services and had received peer led reviews to compare themselves with other similar units and national standards. Overall the hospital met 87% of low secure standards, an increase since the last visit. One hundred percent was achieved for physical

healthcare, discharge, procedural security, workforce and governance . Relational security and service environment were identified as areas in need of improvement

- The provider subscribed to the prescribing observatory for mental health POMH-UK which has a series of audits and quality improvement programmes that providers can take part in.
- Other quality initiatives included staff nomination and recognition awards for the hospital 'going the extra mile', regionally and organisationally.
- The hospital had recently published 'Oaktree news' to give updates on the service to patients, carers, staff and others.
- Several senior clinicians are members of external clinical groups such the Royal College of Psychiatry; Royal College of Nursing learning disability committee; Nursing and Midwifery Council fitness to practice committee; NHS England secure services managers group and the South of England Learning Disability Network . The provider stated that feedback is given following attendance to the various forums and action to benchmark on practice and to improve the service.
- Staff had maintained links with various stakeholders such as National Autistic society.

Outstanding practice and areas for improvement

Outstanding practice

- Staff had developed a restrictive practices group where patients and staff met to reduce blanket rules occurring in the hospital for patients. Patients and staff had developed a range of posters for example to remind staff that 'supportive not restrictive' practice was emphasised.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff reviews of patients in seclusion take place as per their policy and the Mental Health Act 1983 code of practice.
- The provider must review their processes for planning and supporting patients towards their discharge from hospital.

Action the provider SHOULD take to improve

- The provider should review their recruitment and retention policies to reduce the number of staff vacancies.
- The provider should ensure review their process for identifying, managing and removing ligature risks.
- The provider should ensure that patients are effectively involved in debriefs following restraints.
- The provider should ensure that patient care records systems are consistent and that staff have easy access.
- The provider should ensure that electronic patient care records adequately reflect patients' views.
- The provider should review their systems for gaining and acting on feedback from patients regarding food.
- The provider should review their communication systems with carers to ensure they receive regular updates on patients care as relevant.
- The provider should review their systems in place to engage with staff at the hospital.
- The provider should ensure that the hospital comply with reporting requirements for the Workforce Race Equality Standard.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure that staff reviews of patients in seclusion take place as per their policy and the Mental Health Act 1983 code of practice.** Staff did not always undertake reviews of patients in seclusion as per the provider's policy and the Mental Health Act 1983 code of practice. Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 This was a breach of regulation 12 (1) (2)(a)(b).

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 9 HSCA (RA) Regulations 2014 Person-centred care **The provider must review their processes for planning and supporting patients towards their discharge from hospital.** The provider had challenges with moving patients out of the hospital. The average length of stay for patients (now discharged) was 826 days significantly longer than the national average of 554 days. Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 This was a breach of regulation 9 (1)(2)(3)(b).