Lakeside

Quality Report

Lakeside
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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?	Good
Are services well-led?	Requires improvement

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

This service was placed in special measures following the comprehensive inspection carried out in March 2018. Whilst we identified improvements during the comprehensive inspection carried out in January 2019, the provider remained in special measures due to insufficient improvement in the safe domain. As a result of this inspection, the provider is no longer rated as inadequate for any of the five key questions and has demonstrated improvements have been made. The decision has been made to exit the service from special measures.

We rated Lakeside as requires improvement because:

- Emergency grab bags contained some expired stock and some stock was missing. One emergency grab bag was secured with an incorrect tag meaning it could not be accessed quickly in an emergency. Defibrillation machines had parts missing or were not working and one staff member was unclear how to use them. Some wards did not have blood monitoring equipment or urine testing strips. wards that had blood monitoring equipment had not had it calibrated regularly. Emergency drugs bags were stored at ceiling height and some staff could not reach them. However, all issues were rectified during or shortly after the inspection.
- There were delays in signing off and closing incidents that had been reported using the internal incident reporting system.
- Although most care plans had been updated regularly, we found five care plans which had not been updated within the providers monthly timescale, this equated to 21%. One care plan had been reviewed within the providers timescale, but the review lacked detail. Some care plans contained several goals that could have been merged to make them less complicated for patients.
- Staff we spoke with knew the hospital had a freedom to speak up champion, but some were not sure who it was.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a hospital for people with a learning disability and/or autism and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the wards who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff spoke highly of the newly-appointed service director. Leaders knew patients well. Senior managers knew the names and individual personalities of patients. Staff felt respected, supported, listened to and valued.

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	Requires improvement	

Summary of findings

Contents

Requires improvement

Lakeside

Services we looked at:
Wards for people with learning disabilities or autism

Summary of this inspection

Background to Lakeside

Lakeside provides care, treatment and support for patients on the autistic spectrum, and supports with mental health concerns, anxieties, or learning disabilities. The hospital has eight wards for patients who require rehabilitation to move on to residential or supported living. There were 30 patients receiving care and treatment at the time of inspection.

- Elstow 1 ward is a locked ward for up to eight females.
- Elstow 2, a locked ward, provides six beds for younger men (18-25 years).
- Elstow 3, a locked ward provides nine beds for men.
- Elstow 4 ward is a locked ward for up to eight females requiring intensive support.
- Elstow 5 ward provides eight beds for men. This is a locked ward for more stable patients stepping down.
- Cooper 1 ward provides seven beds for men. This is a locked male intensive care and admission ward.
- Cooper 2, a locked ward provides seven beds for men with a learning disability and autism with additional complex needs.
- Gifford ward provides 12 beds for women with diagnostic features of Emotionally Unstable Personality Disorder.

At the time of inspection, the manager was undergoing the registered manager process and a nominated individual was in post. Following inspection, the registered managers application was approved. Lakeside is registered to carry out the following regulated services:

• Treatment of disease, disorder, or injury.

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

Lakeside was previously known as Milton park Therapeutic Campus. The service changed its name in January 2018. The service registered with the CQC in 2005. The CQC has carried out 11 inspections since registering in 2005. The last comprehensive inspection was carried out in January 2019. Following the inspection, CQC rated the provider as requires improvement, we rated safe as inadequate, effective as requires improvement, caring and responsive as good and well-led as requires improvement.

Following the January 2019 inspection, we told the service that it must take the following actions:

- The provider must ensure that patients' capacity to consent to treatment is reviewed regularly.
- The provider must ensure physical health care plans reflect patients current need and are adhered to.
- The provider must ensure that patients sign Section 17 leave forms and they are provided with information relating to their section 17 leave.
- The provider must ensure that accommodation and environment is appropriate for use. Ensuring it is clean, safe and the optimum temperature.
- The provider must ensure that rapid tranquilisation medicine protocol evaluation forms are being completed.
- The provider must ensure that their enhanced observation policy is in line with National Institute for Health and Care Excellence guidance and staff have access to regular breaks.
- The provider must ensure blanket restrictions are justified.
- The provider must ensure that long-term segregation daily review minutes are contemporaneous.
- The provider must ensure that three monthly independent reviews by an external hospital are being carried out for patients in long-term segregation in line with the Code of Practice.

The provider submitted an action plan following the January 2019 inspection and had addressed all concerns adequately prior to our current inspection. This included the closure of long-term segregation and patients had been reintegrated into the main stream provision within the hospital. Seclusion and rapid tranquilisation had also been discontinued. We have continued to monitor the provider with regular engagement and improvement meetings.

Summary of this inspection

Our inspection team

The team that inspected the service included five CQC inspectors, a Mental Health Act reviewer, three specialist professional advisors and an expert by experience.

The team would like to thank all those who met and spoke with them during the inspection.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all eight wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with three carers of patients
- spoke with managers for each of the wards
- spoke with 32 other staff members; including doctors, nurses, health care assistants, occupational therapists, psychologists and administrators
- attended and observed two hand-over meetings a multi-disciplinary meeting and a patient forum
- looked at 23 care and treatment records of patients
- carried out a specific check of the medication management on all 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 16 patients who were using the service.

- Patients said that staff were caring, and kind and the food was OK. Patients told us staff were helpful, supportive and they spent time talking to them.
- Patients said they felt safe and they could talk to the staff if they had any concerns.
- Patients said they had enough activities and they enjoyed taking part in activities.
- Patients with mobile phones told us they could access the hospital Wi-Fi.
- Patients told us they were involved in their treatment and the changes in the hospital, such as the new community centre and developing training packages on autism.

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:

- Maintaining safety for physical health equipment was not always consistent. Emergency grab bags contained some expired stock and some stock was missing. One emergency grab bag was secured with an incorrect tag meaning it could not be accessed quickly in an emergency. Defibrillation machines had parts missing or were not working and one staff member was unclear how to use them. Some wards did not have blood monitoring equipment or urine testing strips. Wards that had blood monitoring equipment had not had it calibrated regularly. Emergency drugs bags were stored at ceiling height and some staff could not reach them. However, all issues were rectified during or shortly after the inspection.

However:

- All wards were safe, clean, well furnished, well maintained and fit for purpose. Staff completed personalised patient fixed-point ligature risk assessments for each patient which were stored in a health and safety folder on each ward.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed

Summary of this inspection

the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).

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

Are services effective?

Good

we rated effective as good because:

- Staff assessed the physical and mental health of all patients within 48 hours of admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and most had been updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Teams included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- We found five care plans which had not been updated within the providers monthly timescale, this equated to 21%. One care plan had been reviewed within the providers timescale, but the review lacked detail.

Are services caring?

Good

we rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

we rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.
- The design, layout, and furnishings of the wards and service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Summary of this inspection

Are services well-led?

we rated well led as requires improvement because:

- There were delays in signing off and closing incidents that had been reported using the internal incident reporting system. We could not be assured there were sufficient systems and processes established to ensure compliance with assessing, monitoring and improving the quality and safety of the services provided.
- Staff we spoke with knew the hospital had a freedom to speak up champion, but some were not sure who it was.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff spoke highly of the newly-appointed service director. Leaders knew the names and individual personalities of patients. Staff felt respected, supported, listened to and valued. Teams worked well together to support patients.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. There had been significant organisational change and change to working practices on the wards. The senior leadership team had involved staff and patients and empowered them to be involved in decisions.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. Staff we spoke with, spoke highly of the hospital and of the senior management team.
- Staff engaged actively in local and national quality improvement activities.
- There was a clear governance structure led by the senior leadership team. The hospital director led an overarching governance meeting, which had information escalated by several sub committees which sat underneath. This had been a recent change to bring about clear decision making for the running of the hospital.

Requires improvement

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff completed mandatory face-to-face Mental Health Act training annually. The average staff compliance with Mental Health Act training was 94%. Agency and bank staff also attended the providers Mental Health Act training.

The Mental Health Act administration team were located within the hospital site. Staff provided care and treatment for 29 detained patients and one informal patient at the time of our inspection. There were good working relationship between the Mental Health Act administration team and the wards, community teams, associate hospital managers and the senior management team.

The Mental Health Act administration team disseminated information, such as updates relating to the Mental Health Act to staff, carried out audits of Mental Health Act paperwork, provided additional training and assessed staff competency and understanding of the Mental Health Act.

The providers' policies relating to the Mental Health Act were developed or updated by the senior Mental Health Act administration manager. They were then sent to the clinical governance committee for sign-off.

The provider had arrangements in place for the receipt and scrutiny of detention paperwork. The Mental Health Act administration team along with the registered nurses could receive detention paperwork. The scrutiny process was multi-tiered, which included the nurse, Mental Health Act administrator and medical scrutiny. The provider had developed checklists to assist staff with the receipt and scrutiny process.

The provider automatically referred all patients, including those who lacked capacity to an independent mental health advocate or independent mental capacity advocate within a few days of admission. The independent mental health advocate attended wards twice weekly for drop-in sessions. The independent mental health advocate also visited for specific appointments and meetings with the patients.

The independent mental health advocate attended various meetings including multidisciplinary team meetings, First Tier Tribunal meetings, managers hearings, care and treatment reviews and care programme approach meetings.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, including in easy to read format.

Some staff we spoke with told us section 17 leave could be difficult to facilitate due to the hospitals rural location and needing to use the hospital car to travel to locations.

We looked at nine care records to analyse section 17 leave documentation. Section 17 leave risk management plans were detailed for each individual and were agreed in collaboration with the patient, carers and family members.

Ward staff completed a Mental Health Act census each month. The census covered important information regarding, for example, section 132 (duty of managers of hospitals to give information to detained patients) The Mental Health Act administration team monitored and audited the information contained within the census and contacted the ward staff if there were any gaps in documentation.

A pharmacist completed monthly audits including the provision of section 58 (treatment requiring consent or a second opinion).

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff completed E-learning Mental Capacity Act and Deprivation of Liberty Safeguards training annually. The average staff compliance with Mental Capacity Act training was 86%. Agency and bank staff also attended the providers Mental Capacity Act training.

There were no Deprivation of Liberty Safeguard applications made by the hospital in the last six months.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

The Responsible Clinician had assessed patients' capacity to consent to treatment in each of the records we reviewed. Capacity was reviewed monthly, audited regularly and discussed at the clinical governance meeting. At the time of inspection, the audit showed the provider was 100% compliant with capacity assessments.

The hospital had Mental Capacity Act Champions who attended external meetings with specialist Mental Capacity Act leads from Bedford.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

The hospital had closed circuit television installed and convex mirrors were in use across the site allowing staff to observe all parts of the wards.

Staff completed regular environmental risk assessments and reviewed these monthly at governance meetings. Staff completed ligature risk assessments annually or more frequently when new equipment was added to areas accessed by patients or changes were made to fixtures or fittings. Ligature points are fixtures to which people intent on self-harm might tie something too to strangle themselves. Staff completed patient fixed-point ligature risk assessments for each patient which were stored in a health and safety folder on each ward.

The provider was compliant with the Department of Health's guidance on the provision of single sex accommodation. All wards were single gender.

The hospital employed a team of housekeeping staff who kept the hospital clean and tidy. Areas were visibly clean throughout the hospital and cleaning records demonstrated that all areas were cleaned regularly.

Staff adhered to infection control principles. The hospital displayed hand washing posters at each sink. Hand sanitizer was available across all areas of the hospital.

Staff and visitors had access to personal alarms which signalled on panels around the wards where an incident had taken place. The hospital had an emergency responder allocated to each ward who carried a pager to respond to incidents quickly. Nurse call bells were present in all bedrooms.

The provider did not have seclusion rooms. The provider had reviewed the need for seclusion, the use of seclusion and the appropriateness of facilities and closed the seclusion room in July 2019. The provider had made the decision to close Cooper 3, the long-term segregation ward in September 2019 and Cooper 3 ward was no longer in use.

The emergency grab bag on Elstow 3 contained some expired stock and some stock was missing. The emergency grab bag on Elstow 5 was secured with a tag which meant that it could not be accessed quickly in an emergency. Following feedback to the service director, all secure tags were taken off of emergency grab bags and a memo sent to staff that they were not required.

The defibrillation machine on Elstow 3 only had one pad and no spare battery, one staff member was unsure how to switch the machine on. Following feedback to the service director all available nurses received defibrillation training the same day and by 12 November all further nurses within the hospital had been trained.

There was no blood monitoring equipment on Elstow 4 or Elstow 3 and no urine testing strips, the physical health nurse confirmed that all wards should have these in place. On Elstow 1 and Elstow 5 the blood monitoring equipment had not been calibrated and on Cooper 2 the blood monitoring machine was not working. On Cooper 2 the weighing scales had not been checked since 2017.

The emergency drugs bags were stored at ceiling height and some staff could not reach them. Following feedback to the service director the emergency drug bags were moved to waist height and steps were purchased.

Safe staffing

At the time of inspection, the hospital had vacancies for a part-time consultant psychologist, an occupational therapist, an occupational therapist assistant, a speech and language therapist, a kitchen assistant. Eight healthcare assistants and three nurses had been recruited and were awaiting start dates, meaning the hospital had no vacancies for nurses or healthcare assistants.

Between 21 October 2018 and 27 October 2019, the hospital had 996 hours covered by agency staff, 713 of the hours was for healthcare assistant support and 283 hours of qualified nurse cover.

Clinical general managers discussed staffing at daily hub meetings on each ward and adjusted the daily staffing levels dependant on patient need and additional observations. Staff could be accessed quickly if needed to provide additional support for increased observations. Clinical general managers were supernumerary to daily staffing numbers.

Staffing numbers for October 2019 matched the staffing rotas and met safe staffing guidelines. The hospital could use agency staff as required.

Agency nurses were familiar with the ward they were working on. The hospital had recently started using one agency to supply staff meaning the same nurses were being used on a more regular basis.

During the inspection a qualified nurse was present on the wards at all times.

Patients told us they had regular one to one time with their named nurse.

Patients told us activities were rarely cancelled and they had access to activities both on and off the wards. However, some staff we spoke with told us organising escorted leave could be difficult as there was only one car available for escorted leave and a limited number of drivers. Due to the rural location of the hospital most escorted leave took place in nearby towns.

The hospital employed a physical health nurse to carry out physical healthcare interventions.

The hospital had adequate medical cover day and night and a doctor could attend the hospital quickly in an emergency.

Staff received and were up to date with appropriate mandatory training and the average mandatory training rate for permanent staff was 89%. Mandatory training included immediate life support delivered during emergency first aid at work, Mental Health Act, Mental Capacity Act and DoLS, safeguarding Level 2 and data protection.

Assessing and managing risk to patients and staff

We looked at 23 sets of patient care records across the wards. All records demonstrated that staff assessed risks to patients and themselves. Staff used recognised risk assessment tools throughout the hospital, which were accessible by all staff for review. These included the historical clinical risk management-20 for secure environments (HCR-20) tool, which is a comprehensive set of professional guidelines for the assessment and management of violence risk, START (Short-Term Assessment of Risk and Treatability) and The Risk for Sexual Violence Protocol (RSVP) where applicable.

Staff updated risk assessments regularly, including after an incident. Patients' risks were discussed and reviewed daily at the morning hub meetings and monthly by the multidisciplinary team.

At the time of inspection there was one informal patient. Informal patients could leave at will and all doors displayed signs, including in easy to read versions.

The provider had no episodes of seclusion since May 2019 and closed the seclusion room in July 2019. Between January 2019 and May 2019 there had been eight episodes of seclusion.

Since our inspection in January 2019 the provider had closed Cooper 3 ward which was used for long-term segregation, patients residing in long-term segregation were successfully integrated into other wards within the hospital or had been discharged to other more suitable hospital placements.

Between January 2019 and July 2019 there were 449 uses of restraint. This had decreased since our previous inspection by 36%. Use of physical restraint was separated in to levels of restriction. Overall, 156 were classified as high restrictive (supine), 200 were classified medium restrictive

(holding & escort, seating & kneeling), 47 were non-restrictive (assault avoidance & redirection) and 46 were verbal. The overall reduction in high restriction restraint since the as inspection was 37%.

Between January 2019 and July 2019 there was one use of prone restraint recorded. However, this was investigated and not substantiated as it had been incorrectly recorded.

Staff told us they only used restraint after verbal de-escalation had failed and using correct techniques. Overall, 93% of permanent staff and 83% of bank staff were trained in physical intervention. The hospital only used agency staff who had received the same physical intervention training. The provider had approached a new company for physical intervention training which focussed on developing person-centred approaches using a positive behaviour support model. Training was due to commence shortly after inspection and would be offered to all staff, including bank and agency staff. The provider had risk assessed the transition period between the old and new training being delivered across the hospital.

The hospital had recently audited the use of rapid tranquilisation and had adopted the principle that they did not use PRN rapid tranquilisation. Where rapid tranquillisation was required it was part of a patients care plan and was agreed by the on-call duty doctor. The hospital had recently created a policy to reflect this. Between 01 July 2019 and 01 October 2019 there were six occasions of rapid tranquilisation which had reduced by 70% since our previous inspection where there were 20 occasions of rapid tranquilisation used within a three-month period. rapid tranquilisation monitoring forms were detailed and thorough.

The provider's observation policy followed the National Institute for Health and Care Excellence guidance on violence and aggression: short-term management in mental health, health and community settings. Staff followed policies and procedures for observing patients. Enhanced observations were used when indicated by risk. Staff carried out searches of patients and property upon admission and following unescorted leave, in line with the providers policy.

Safeguarding

Staff were trained in safeguarding and knew how to make a safeguarding alert. Overall, 82% of permanent and agency staff had completed safeguarding level 2 training. The hospital had access to an internal safeguarding manager who could offer advice and support to all staff and worked closely with the local authority safeguarding team.

Staff understood how to protect patients from abuse and the service worked well with other agencies and the internal safeguarding manager to do so.

Between 30 September 2018 and 30 September 2019, 19 safeguarding concerns were raised to the CQC from Lakeside.

There were procedures in place for children to visit the hospital. There was a family visiting room located within the hospital.

Staff access to essential information

Staff used a paper recording system for patient care records.

Staff kept detailed paper records of patients' care and treatment in a secure cabinet in the ward office.

Patient records were clear, up-to-date and easily available to all staff providing care, including agency staff.

Medicines management

There was good medicines management practice including the storage, dispensing and medicines reconciliation. The hospital used an external pharmacy service to audit medication. The external pharmacy representative attended the clinical governance meeting quarterly.

Staff reviewed the effects of medication on patient's physical health regularly and in line with NICE guidance.

Track record on safety

The hospital reported no serious incidents in the 12 months leading to inspection.

Between 30 September 2018 and 30 September 2019, 67 statutory notifications were sent to the Care Quality Commission from Lakeside. Incidents reported included patients ingesting items, patient injuries, patient assaults on other patients and patient assaults on staff. The hospital provided further information when requested, investigated incidents when required, and dealt with all incidents appropriately.

Requires improvement

Wards for people with learning disabilities or autism

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how and what incidents to report. Staff used a computerised incident reporting system and managers investigated all incidents. Staff could describe incidents that would require reporting, such as violence, injury or aggression.

Staff discussed all behavioural incidents each morning at individual hub meetings with the doctor, nurse, therapist and the ward team. Notes from these meeting were then recorded on the ward's daily notes and 24-hour report. The clinical general managers met with the service director, the medical director and head of therapies to further discuss events and agree actions. During these meetings actions were assigned, recorded and disseminated. The provider justified the delays in signing off due to actions that had been allocated to clinical general managers that required further follow-up, investigation or monitoring and due to the clinical general managers being realigned to new areas of responsibility.

Staff reported all incidents that should be reported. Incidents were logged on to the computerised recording system as a near miss, an accident or an incident.

Staff were open and transparent and explained to patients if and when things went wrong. The hospital had a duty of candour policy which staff were aware of. We were shown a letter that was sent to a patient in line with the providers duty of candour policy.

Learning from incidents was shared through the governance process. Incidents were documented in each wards 24-hour report, discussed during daily hub meetings, monthly team meetings, monthly reflective practice sessions and clinical governance meetings. Learning was documented within meeting minutes. Lessons learnt were available for staff to view in team meeting minutes and clinical governance meeting minutes. However, some staff we spoke with said they did not have time to review minutes and due to working on a shift rota did not always attend team meetings, so did not know about lessons learnt from incidents. A small number of staff said they were unable to attend hub meetings due to patient observation levels and therefore were unaware of any learning outcomes.

We saw evidence of staff debrief located in folders on wards, in addition staff had access to monthly reflective practice sessions. Staff confirmed that patients received a debrief following an incident.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at 23 sets of care and treatment records for patients. Staff assessed the physical and mental health of patients within 48 hours of admission.

Staff developed individual care plans which were mostly reviewed regularly through multidisciplinary discussion and updated as needed. We found two care plans for patients on Cooper 1 that had not been updated within the providers monthly timescale. On Cooper 3, one patient had not had their care plan updated since 22/08/2019. On Elstow 5 one care plan referred to a capacity discussion held in 2004 and one patients care plan had been reviewed but the review lacked detail. On another ward, one patient's care plan for sleep apnoea had not been updated since 25/07/2019 and the same patients care plan for asthma management had not been updated since 19/04/2019.

We looked at 23 physical health care plans, on Cooper 1, one care plan did not have a plan specific to the patient's risk of choking/ ingestion.

Care plans were personalised, holistic and recovery-orientated. Care plans were in the patient's voice and could also be completed in easy read. However, some care plans contained several goals with similar themes which could have been combined to make them more manageable.

Staff completed individualised positive behavioural support plans for patients. Staff had a good understanding of individual needs of patients. Behaviour support plans detailed personalised interventions to change behaviour pro-actively and manage behaviour reactively and included effective monitoring of behaviour.

Requires improvement

Wards for people with learning disabilities or autism

Best practice in treatment and care

Patients had access to a range of activities, groups and one to one sessions delivered by the therapeutic services team as recommended by the National Institute for Health and Care Excellence. Occupational therapy groups included breakfast and lunch making, self-care, budgeting, physical activities and arts and crafts. The psychology team offered a range of groups including relapse prevention and moving on, cognitive behaviour therapy, mental health awareness, coping skills and risk awareness. Therapy staff carried out daily role modelling on all wards.

The hospital had a specialist Dialectical Behavioural Therapy (DBT) service. Gifford ward, for females, was led by an accredited DBT therapist and the team consisted of intensively trained DBT therapists. All ward staff were trained in the model at skills level. Gifford ward provided a therapeutic ward underpinned by DBT principles. Dialectical Behavioural Therapy (DBT) treatment is a type of psychotherapy or talking therapy that utilises a cognitive-behavioural approach and emphasises the psychosocial aspects of treatment. The hospital also offered adapted DBT programmes and family therapy.

Patients had access to a range of activities, groups and one to one sessions delivered by the therapeutic services team as recommended by the National Institute for Health and Care Excellence. Occupational therapy groups included breakfast and lunch making, self-care, budgeting, physical activities and arts and crafts. The psychology team offered a range of groups including relapse prevention and moving on, cognitive behaviour therapy, mental health awareness, coping skills and risk awareness.

All patients had an activity planner which indicated their daily activities. Staff amended and created patient's activity planners dependent on levels of functioning. Some patients had a daily or weekly planner, some patients' planners only included the activity they were due to take part in next.

The hospital employed a physical health nurse to manage patients' physical health alongside the GP. All patients saw the GP, who attended the hospital weekly, within a week of admission. The practice nurse offered weekly smoking cessation clinics for patients and health promotion groups including health and hygiene, insomnia, healthy eating and physical activity and mental health. Patients were offered cervical screening tests with the practice nurse.

The hospital had a contract with local personal trainers who specialised in working with people who had mental health and learning difficulties. All patients were offered personal training sessions weekly and the hospital had recently purchased two bikes for patients to use.

The hospital invited a specialist dentist and chiropodist to attend the hospital regularly to support with dental and foot care and a dietician who attended weekly.

Staff completed assessments of nutrition and hydration and care plans were in place for specific patients. One patient with a high body mass index had a Malnutrition Universal Screening Tool (MUST) completed but it was not clear if the patient had been referred to the dietician, or if they were being monitored weekly.

The hospital used a variety of tools to capture outcome measures including a specialist Health of the Nation Outcome Scale designed for use with people with a learning disability. Occupational therapists used the Montreal Cognitive Assessment (MoCA) and the Model of Human Occupation (MoHO) which provides a framework to understand how to use daily activities therapeutically to support people's health.

Skilled staff to deliver care

The provider employed a therapeutic services team which included doctors, clinical psychologists, assistant psychologists, occupational therapists, occupational therapy assistants and an art therapist. At the time of inspection, the hospital had a vacancy for a speech and language therapist (SALT) and was awaiting start dates for two SALT assistants. The hospital had a contract with an external speech and language therapist who attended the hospital weekly.

Patients had access to a GP weekly and a practice nurse who worked at the hospital full time. A pharmacist and a dietician also visited the hospital weekly.

Managers provided new staff with an appropriate induction. The provider had an induction programme that all staff, including agency staff, were required to attend. Overall, 100% of staff had attended the providers induction programme.

Managers provided staff with supervision and staff had regular access to team meetings. Overall, the number of qualified nurses and healthcare assistants who received supervision between May and October 2019 was 87%.

Supervision for other roles within the hospital including administrative staff and the therapeutic services team was 100%. The number of staff who received appraisal in October 2019 was 79%.

Managers ensured that staff received the necessary specialist training for their roles. Staff told us they had attended additional training to support them in their roles. Staff were trained to work with patients with a learning disability. Examples of specialist training included diabetes, epilepsy, autism and relationships, hording and cluttering and eating well- supporting adults with a learning disability. The provider sent a list to all staff with additional specialist training opportunities and dates.

Managers dealt with poor staff performance promptly and effectively during supervision. Staff suspensions were discussed at monthly clinical governance meetings. We saw evidence within staff supervision files of staff being supported to return to work following sickness.

Multi-disciplinary and inter-agency team work

The hospital held a variety of staff meetings, including twice daily handovers, team meetings, clinical governance meetings and reflective practice sessions. In addition to this the provider held regular staff open sessions and a weekly HR surgery.

Staff held handovers twice daily which then fed into the morning meeting with senior managers. However, some healthcare assistants told us they were unable to attend handovers due to carrying out observations. All wards had effective working relationships, including good handovers, with the therapeutic services team.

All wards had effective working relationships with teams outside the organisation including with care co-ordinators, the local acute hospital and the local safeguarding team. Nursing staff invited community care coordinators and commissioners to multidisciplinary meetings and reviews.

Adherence to the MHA and the MHA Code of Practice

Staff completed mandatory face-to-face Mental Health Act training annually. The average staff compliance with Mental Health Act training was 94%. Agency and bank staff also attended the providers Mental Health Act training.

The Mental Health Act administration team were located within the hospital site. Staff provided care and treatment for 29 detained patients and one informal patient at the time of our inspection. There were good working relationship between the Mental Health Act administration team and the wards, community teams, associate hospital managers and the senior management team.

The Mental Health Act administration team disseminated information, such as updates relating to the Mental Health Act to staff, carried out audits of Mental Health Act paperwork, provided additional training and assessed staff competency and understanding of the Mental Health Act.

The provider policies relating to the Mental Health Act were developed or updated by the senior Mental Health Act administration manager. They were then sent to the clinical governance committee for sign-off.

The provider had arrangements in place for the receipt and scrutiny of detention paperwork. The Mental Health Act administration team along with the registered nurses could receive detention paperwork. The scrutiny process was multi-tiered, which included the nurse, Mental Health Act administrator and medical scrutiny. The provider had developed checklists to assist staff with the receipt and scrutiny process.

The provider automatically referred all patients, including those who lacked capacity to an independent mental health advocate or independent mental capacity advocate within a few days of admission. The independent mental health advocate attended wards twice weekly for drop-in sessions. The independent mental health advocate also visited for specific appointments and meetings with the patients.

The independent mental health advocate attended various meetings including multidisciplinary team meetings, First Tier Tribunal meetings, managers hearings, care and treatment reviews and care programme approach meetings.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, including in easy to read format.

Some staff we spoke with told us section 17 leave could be difficult to facilitate due to the hospitals rural location and needing to use the hospital car to travel to locations.

We looked at nine care records to analyse section 17 leave documentation. Section 17 leave risk management plans were detailed for each individual and were agreed in collaboration with the patient, carers and family members.

Requires improvement

Wards for people with learning disabilities or autism

Ward staff completed a Mental Health Act census each month. The census covered important information regarding, for example, section 132 (duty of managers of hospitals to give information to detained patients) The Mental Health Act administration team monitored and audited the information contained within the census and contacted the ward staff if there were any gaps in documentation.

A pharmacist completed monthly audits including the provision of section 58 (treatment requiring consent or a second opinion).

Good practice in applying the MCA

Staff completed E Learning Mental Capacity Act and Deprivation of Liberty Safeguards training annually. The average staff compliance with Mental Capacity Act training was 86%. Agency and bank staff also attended the providers Mental Capacity Act training.

There were no Deprivation of Liberty Safeguard applications made by the hospital in the last six months.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

The Responsible Clinician had assessed patients' capacity to consent to treatment in each of the records we reviewed. Capacity was reviewed monthly, audited regularly and discussed at the clinical governance meeting. At the time of inspection, the audit showed the provider was 100% compliant with capacity assessments.

The hospital had Mental Capacity Act Champions who attended external meetings with specialist Mental Capacity Act leads from Bedford.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed caring interactions between staff and patients.

We spoke with 16 patients. Patients said that staff were caring, and kind and the food was OK. Patients told us staff were helpful, supportive and they spent time talking to them.

Patients said they felt safe and they could talk to the staff if they had any concerns.

Patients had access to an Independent Mental Health Advocate who regularly visited the hospital.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Involvement in care

Patients received an informational handbook upon admission, were shown around the ward and the hospital and were introduced to patients and staff.

Patients we spoke with confirmed they were involved in their care planning. Care plans were mostly written in the patient's voice.

Staff communicated with patients, so they could understand their care and treatment. We saw staff using Makaton to communicate with a patient. Makaton uses signs and symbols to help people communicate.

Patients were involved in the development of the new catering services offered at the hospital and had requested a later dinner time of 18:00 pm which was granted. One patient we spoke with was designing an autism training package to be delivered to staff. Therapy staff requested patient feedback about therapy sessions and tailored or amended sessions to suit patient needs.

Requires improvement

Wards for people with learning disabilities or autism

Patients could give feedback on the service they received through the patient forum, patient surveys and via a suggestions box.

Patients had access to an independent advocate who visited the hospital twice a week.

Staff informed and involved families and carers appropriately. Carers were invited to multi-disciplinary meetings, were offered DBT family therapy and dependant on patient agreement could receive weekly updates on their family members progress.

We spoke to three family members of patients who currently or had previously stayed at Lakeside. Family members told us that the care was generally good, but the high staff turnover had unsettled patients. However, staff treated patients as individuals and capitalised on their strengths. One family member told us there could be issues with Section 17 leave, as there was only one car to transport patients to nearby towns and if that car was in use to take a patient on home leave then other patients could not go out. Family members all confirmed they attended or were invited to multi-disciplinary meetings and they were involved in care. One family member told us they could ring or email for an update on their family members progress. One family member we spoke with told us the move had been the best thing that had happened to their daughter, that their daughter had an amazing team around them who were well trained, and the therapies team had worked with ward staff to provide a really positive outcome. Family members said the new service director listened to patients and was responsive to ideas.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

At the time of inspection, the overall occupancy rate for the hospital was 46%.

Managers told us three long term patients had remained at the service for over 10 years. The provider was working with commissioners and families to support these patients in moving on to more suitable accommodation. The provider was working with community teams and commissioners to transfer eight further patients to more appropriate placements.

Due to the specialist nature of the hospital most patients were from out-of-area.

Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and in the interests of the patient. Managers and staff ensured that when patients were moved or discharged this was planned and happened at an appropriate time of day.

Staff planned for patients' discharge, including liaison with care managers, care co-ordinators and family members. Patients we spoke with confirmed they were involved in their discharge planning.

Staff supported patients to access external appointments including acute hospital appointments and during referrals and transfers, for example home leave.

The provider reported no delayed discharges in the year leading up to inspection.

The facilities promote recovery, comfort, dignity and confidentiality

Patients could personalise their bedrooms. We saw pictures, photos and art work displayed in patients' bedrooms. On admission, if patients wanted their rooms painted they were provided with a colour chart to choose a new colour for their bedroom walls.

Patients could store their possessions securely in a safe in their bedrooms.

Across the wards, patients had access to a lounge area with appropriate furniture, a TV, music and games. At the time of inspection, the community centre, known as the star centre was closed and being refurbished into a lounge area with a pool table and computers for patients. Part of the community centre was being redesigned for use by the therapy team to include an art room, an occupational therapy kitchen and an updated gym. There were plans in place for the new community centre to include a tuck shop which would be ran by patients.

There was an appropriate room for people visiting patients off the wards.

Requires improvement

Wards for people with learning disabilities or autism

Patients were permitted use of a phone to make phone calls. Some patients had access to personal mobile phones. Patients could also use a webcam service to speak to family members, community care co-ordinators and friends.

All patients had access to enclosed outdoor space.

The provider had recently reviewed the catering services provided at Lakeside and following consultation with patients had developed a three-week rolling menu with a focus on healthy balanced diets. Patients told us the food offered was good quality.

Staff kept the kitchen areas locked on each of the wards. Patients we spoke with said they could access the kitchen when required to make drinks or snacks.

Patients' engagement with the wider community

Patients could take part in employment within the hospital grounds, the hospital had a patient who was employed to paint and maintain the allotment. Employment opportunities were being developed in line with the community centre update.

Patients could take part in volunteering within the local community.

Staff supported patients to maintain contact with their families and carers. With patient consent, families and carers were involved in patient care.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community.

Meeting the needs of all people who use the service

The hospital had made suitable adjustments for people requiring disabled access on the ground floor of all wards. The hospital had no lifts to support access to the first floors.

The hospital had a range of leaflets available including information on patients' rights, how to complain and access advocacy. Staff displayed information on walls and notice boards. Patients were given an information pack on admission.

Leaflets and information was available in other languages for patients for whose first language was not English. Staff told us patients could access an interpreter if required, either face to face or over the phone. Information was also displayed in easy read format.

The hospital catered for all dietary and religious requirements.

Patients told us they had access to appropriate spiritual support both on and off the wards.

An independent advocate visited the hospital twice a week to support patient needs.

Listening to and learning from concerns and complaints

In the year leading up to inspection the provider received 21 complaints, ten of which were upheld.

The hospital treated concerns and complaints seriously, investigated them and learned lessons from the results. Managers shared lessons to staff via meetings.

Staff discussed complaints at the ward team meetings, the daily hub meetings and the daily managers meeting. Staff we spoke with said they were aware of ongoing complaints.

Patients we spoke with were aware of the complaints process and ways in which they could complain.

Staff provided a patient who complained regularly with a complaints booklet which was then reviewed and discussed with the patient daily.

Between July 2019 and October 2019, the provider received five compliments. Three compliments were from patients, two from family members and one from a patients care team.

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

Requires improvement

Leadership

Staff spoke highly of the newly-appointed service director. Leaders knew the names and individual personalities of patients. Both staff and patients spoke highly of the senior management team.

Leaders had a good understanding of the hospital and the services they managed. They could explain clearly how the teams were working to provide high quality care on wards.

Staff knew who senior managers were within the hospital and said they visited wards on a regular basis. Staff felt all managers were approachable.

Requires improvement

Wards for people with learning disabilities or autism

Leadership and professional development opportunities were available for staff. We saw evidence of career development through speaking with staff. In a recent staff survey completed by the provider, 86% of staff felt they had the opportunity to develop their career.

Vision and strategy

Staff were aware of the provider's visions and values which were displayed across the hospital. Accomplish values were quality, celebrate uniqueness, fun, brave and move mountains. We observed staff behaviour and it reflected the provider's values.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff within the service and responded swiftly and appropriately when staff performance fell below expectation.

Staff were measured against the company values through the appraisal process.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff attended a variety of meetings where they had the opportunity to voice ideas including regular open sessions where staff could discuss any questions or concerns with Senior Management. The provider emailed the ongoing action and improvement plan to staff regularly to keep them updated on changes and developments. In a recent staff survey completed by the provider, 93% of staff said they welcomed the recent changes at Lakeside.

Culture

Staff felt respected, supported, listened to and valued. Overall, 86% of staff said they felt valued by their colleagues in a recent staff survey. Staff felt positive and proud about working for the provider and their team. Staff we spoke with, spoke highly of the hospital and of the senior management team. In a recent staff survey completed by the provider 80% of staff said they would recommend Lakeside Hospital as a good place to work.

Staff were open, honest and transparent. Staff explained to patients when things went wrong and referred to advocacy to help with this. We saw evidence in complaints records that staff had fed back openly to patients about complaints and saw evidence of a duty of candour letter that had been sent to a patient.

Staff felt able to raise concerns without fear of retribution. Overall, 93% of staff in a recent survey said they felt supported to speak out and report something that made them feel uncomfortable. However, some staff members we spoke with were unclear on the process of whistle-blowing.

Staff we spoke with knew the hospital had a freedom to speak up champion, but some were not sure who it was. However, the freedom to speak up champion was publicised throughout the hospital, had been recruited by staff and met all new staff on induction. In addition, a whistle blowing anonymous e-mail address was advertised to staff which anyone could use to raise concerns.

Managers dealt with poor staff performance when needed. We saw evidence of poor performance being managed through supervision or formally within investigation processes. The provider used formal processes such as suspension and disciplinary action when required. Managers supported staff to return to work swiftly following work-related injuries by offering staff to return to non-patient facing duties.

In the twelve months leading up to inspection the provider reported that 138 staff members had left the service, equating to 56% of the workforce. The senior management team explained that this was due to the number of changes made within the hospital and the cultural shift within the hospital to ensure staff were more accountable, which resulted in a higher than average turnover of staff.

Teams worked well together and where there were difficulties, managers dealt with them appropriately. We saw good joint working within the hospital between the therapeutic services team, housekeeping, catering and maintenance, administrators, Mental Health Act admin and safeguarding.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

Governance

There was a clear framework of what must be discussed at ward, team or directorate level and in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had access to the wards 24-hour report which contained lessons learned from incidents and clinical governance meeting minutes were located on the shared drive.

Requires improvement

Wards for people with learning disabilities or autism

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding notifications. The provider had an ongoing action and improvement plan which staff were aware of and contributed to.

Between 03 July 2019 and 12 November 2019, Lakeside had 311 incidents that had been reported using the internal incident reporting system that required closing or were awaiting sign off. The highest number was 171 incidents on Elstow 2. Although the incidents had been appropriately investigated and learning disseminated, the actions remained open, awaiting sign off. The provider justified the delays in signing off due to actions that had been allocated to clinical general managers that required further follow-up, investigation or monitoring and due to the clinical general managers being realigned to new areas of responsibility.

Staff carried out audits across the hospital, these included patient file audits, Mental Health Act and Mental Capacity Act compliance audits, physical health care plan compliance audits and staff observation audits. Staff carried out further audits on a selection of topics including rapid tranquillisation and PRN medication. Results from audits were collated, fed back and discussed at the monthly clinical governance meetings. The hospital used an external pharmacy service to audit medication. The external pharmacy representative attended the clinical governance meeting quarterly.

The provider used key performance indicators to monitor the performance of the team's compliance in key areas such as sickness, supervision and training. These were discussed at clinical governance meetings. The provider had recently developed and implemented a new sickness/ absence policy to take positive action on monitoring staff sickness levels. Staff sickness, work related injuries, staff suspensions and return to work support was discussed at the monthly clinical governance meeting and

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

The service had plans for emergencies, for example, adverse weather or a flu outbreak.

The hospital had undergone recent refurbishments and improvements, including the star centre being redeveloped. Patients were involved in the redevelopment and did not feel their care had been compromised by the changes.

Information management

The service collected, analysed, managed and used information to support all its activities, and to monitor effectiveness of the service.

All staff, including bank and agency staff, had access to the information they needed to provide safe and effective care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included a centralised recommendation tracker which was accessible to all staff and identified learning from safeguarding alerts and investigations, notifications and accidents. The tracker was updated in real time meaning ward staff were alerted to these lessons learnt and recommendations immediately. However, there were 311 incident actions which remained open, awaiting sign off. This was due to the administration governance of the on-line system and changes in staffing structure.

Managers had easy access to information relating to complaints, compliments, training compliance and staff sickness.

Staff made notifications to external bodies as needed.

Engagement

Lakeside carried out regular staff surveys to identify any staff issues and staff satisfaction. Results of the staff surveys were generally positive.

The hospital was facilitating a weekly HR surgery to offer the opportunity for staff to discuss pay, annual leave, sickness and to boost staff morale.

Staff had access to an external provider offering an employee assistance programme for staff to receive support on health, home issues, work issues and access online counselling.

Patients could give feedback on the service they received through the patient forum, patient surveys and via a suggestions box.

Requires improvement

Wards for people with learning disabilities or autism

Patients were involved in decision-making about changes to the service. Patients were asked about how they would like the wards decorated and were involved in the redevelopment of the community centre. One patient we spoke with was developing an autism training package to be delivered to staff.

Staff had the opportunity to voice ideas and give feedback on the service at regular open sessions where staff could discuss any questions or concerns with Senior Management. The provider emailed the ongoing action and improvement plan to staff regularly to keep them updated on changes and developments. Staff could also feedback on the hospital and service development through team meetings, the anonymous email service, the HR surgery and suggestions boxes. Staff said they were involved in the development of the hospital by adding to the new service directors mind-map about how the service could evolve and improve.

The provider had taken steps to increase staff retention, including offering a free bus service for staff to get to and from work, relocation payments, a welcome bonus and an annual bonus.

Learning, continuous improvement and innovation

Innovations were taking place within the service. Senior healthcare assistants were being trained and recruited as positive behavioural support mentors. All senior healthcare assistants were required to undertake additional positive behavioural support training.

The provider had adopted the STOMP health care pledge across the hospital. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. STOMP is a national campaign to encourage services to stop the over-use of these medicines and so improve people's quality of life.

Lakeside was awarded with 100% CQUIN attainment in 2018 for the third year in a row. CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

In 2018 the hospital was awarded 3 Qs from the All Wales Framework for the second year in a row for Elstow 3. Elstow 1 and Elstow 2 were registered and audited in 2018 and given a 3 Q rating.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure emergency grab bags and emergency equipment is fit for purpose, fully stocked, and staff have access to appropriate equipment to carry out physical health monitoring on the wards.
- The provider must ensure that incidents awaiting sign off or closing on the internal incident reporting system are closed without unnecessary delay.

Action the provider SHOULD take to improve

- The provider should ensure that care-plans are updated regularly, and the reviews are detailed.
- The provider should ensure that staff are aware who the freedom to speak up champion is.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that the equipment used by the service provider for providing care or treatment to service users was safe for such use and was used in a safe way, or that there were sufficient quantities of these to ensure the safety of service users and to meet their needs.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with assessing, monitoring and improving the quality and safety of the services provided.