Requires improvement

Accomplish Group Support Limited

Lakeside

Quality Report

Lakeside
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-121852568	Lakeside	Lakeside Hospital	MK44 3AS

This report describes our judgement of the quality of care provided within this core service by Lakeside. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Lakeside and these are brought together to inform our overall judgement of Lakeside.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

This service was placed in special measures following the comprehensive inspection carried out in March 2018. While there has been improvement overall there has been insufficient improvement in the safe domain and the service therefore remains in special measures. The service will be kept under review and where necessary another inspection will be conducted within six months. If there is not enough improvement we will move to urgent enforcement action.

We rated Lakeside as requires improvement because:

- There were some improvements needed to the physical environment. Cooper 3, the behavioural support unit for patients in long-term segregation was cramped, dark and tired. The floors in the bathrooms and communal areas were dirty and the unit needed refurbishment. Staff had not adequately carried out security checks. On Elstow 1 unit there was a strong smell of drains. Some bedrooms and bathrooms on Elstow 1 and Elstow 2 units were cold.
- On Elstow 2 unit, only one of the four patients on the unit had access to a key for their own room. This was not indicated in patients' individual risk assessments or care plans to clearly justify this level of restriction.
- The provider's observation policy did not follow National Institute for Health and Care Excellence guidance, which meant staff were spending longer than recommended observing patients.
- We found issues with paperwork including staff not completing required evaluation forms following rapid tranquilisation, some long-term segregation daily review notes had been cut and pasted from previous days and physical health care plans that did not reflect patients' current needs and were not always being adhered to.
- Three monthly independent reviews of long term segregation by an external hospital were not being carried out.
- We found delays in reviewing patients' mental capacity to consent to treatment and staff did not provide patients with information relating to their section 17 leave.
- Healthcare assistants did not feel involved or informed about outcomes from clinical governance meetings.

However:

- Staff completed ligature risk assessments annually or more frequently when needed. Staff completed patient specific fixed-point ligature risk assessments for each patient.
- Staff assessed the physical and mental health of patients within 48 hours of admission. Staff developed individual care plans which were reviewed and updated as needed. Care plans were personalised,

holistic and recovery-oriented. Staff completed individualised positive behavioural support plans for patients. Staff had a good understanding of individual needs of patients. The hospital employed a practice nurse to manage patients' physical health alongside the GP. A specialist dentist also attended bi-weekly.

- The hospital offered employment opportunities to eligible patients within the hospital grounds and had a recovery college based on site. Patients could take part in volunteering within the local community. Patients had access to the star centre, a multifunctional space for therapy groups and leisure activities. All patients were asked if they wished to have carers or relatives involved in discussions about their care.
- The hospital was taking steps to improve morale and staff retention. The management team had worked towards a cultural shift within the hospital and an opportunity to refresh the workforce with a successful recruitment process, which resulted in a higher than average turnover of staff. The hospital recruited a new team of unit general managers in September 2018, which improved staff morale and supported developing leadership within the hospital. Unit general managers felt valued, respected, rewarded and supported. Staff were passionate about the client group they were working with and reflected the providers values.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Inadequate 

we rated safe as inadequate because:

- The environment on Cooper 3 was cramped, dark and tired, the floors in the bathrooms and communal areas were dirty and the unit needed refurbishment. Staff had not adequately carried out security checks. On Elstow 1 there was a strong smell of drains.
- On Elstow 2 only one of the four patients on the unit had access to a key for their own room. This was not indicated in patients' individual risk assessments or care plans to clearly justify this level of restriction.
- The provider's observation policy did not follow National Institute for Health and Care Excellence guidance on violence and aggression: short-term management in mental health, health and community settings. This meant that staff spent longer observing patients than recommended.
- Permanent staff were trained using a different physical intervention technique to agency staff. This posed a risk to staff and patients if staff were following two different approaches.
- Staff were not routinely completing required evaluation forms following rapid tranquilisation.
- There were no records showing that staff had debriefed with managers following an incident.
- Three monthly independent reviews by an external hospital were not being carried out for patients in long-term segregation. Some daily review notes had been cut and pasted from previous days.

However:

- Managers completed ligature risk assessments annually or more frequently when needed. Staff completed patient specific fixed-point ligature risk assessments for each patient.
- Each unit had a fully equipped clinic room. Medication and clinic rooms were audited weekly. Each unit had access to an emergency resuscitation bag to use in a medical emergency. The hospital used an external pharmacy service to audit medication. The external pharmacy representative attended the clinical governance meeting quarterly.
- Staff had access to personal alarms which signalled on panels around each unit where an incident had taken place. The hospital had a bleep holder allocated to each unit who carried a pager to respond to incidents quickly.

Summary of findings

- Overall, 89% of staff had completed mandatory training. This included 87% of staff being trained in safeguarding level 2.
- Staff completed an initial risk assessment for all patients. Staff updated risk assessments regularly, including after an incident.

Are services effective?

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Physical health care plans did not reflect patients' current needs. Staff were not always adhering to them or updating them regularly. We found care plans that did not include patients' physical health issues.
- Staff were not reviewing patients' mental capacity regularly. We found delays in reviewing patients' capacity to consent to treatment.
- Staff did not provide patients with information relating to their section 17 leave. Carers and professionals involved in patients' care were not provided with copies of section 17 leave.

However:

- Staff assessed the physical and mental health of patients within 48 hours of admission. Staff developed individual care plans which they reviewed and updated as needed. Care plans were personalised, holistic and recovery-orientated. Staff completed individualised positive behavioural support plans for patients.
- Patients had access to a range of activities, groups and 1-2-1 sessions delivered by the therapeutic services team.
- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication across the hospital.
- The hospital employed a practice nurse to manage patients' physical health alongside the GP. A specialist dentist also attended the hospital.
- Managers provided new staff with an appropriate induction. Overall, 89% of eligible staff had received an annual appraisal. Staff compliance with Mental Health Act training was 94%. Staff compliance with Mental Capacity Act training was 98%.
- The provider automatically referred all patients, including those who lacked mental capacity to an independent mental health advocate or independent mental capacity advocacy within a few days of admission.

Are services caring?

We rated caring as good because:

Good

Summary of findings

- We observed staff treating patients with kindness, dignity and respect. This was confirmed by most patients.
- Patients gave examples of how staff helped them, for example, managing daily living skills such as money budgeting, cooking, cleaning and supporting them to do their laundry.
- Patients had access to an independent mental health advocate who regularly visited the units.
- Staff had a good understanding of individual needs of patients and their behavioural support plans.
- Care and treatment records demonstrated that patients had been involved in their care plans.
- Staff asked all patients if they wished to have carers or relatives involved in discussions about their care.

However:

- Two patients on Elstow 1 said staff can sometimes be abrupt and were not always visible.
- Nine patients had not received a copy of their care plan which equated to 28%.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients could personalise their bedrooms.
- Patients had access to the star centre, a multi-functional space for therapy groups and leisure activities. Patients could access the star centre café for freshly made breakfast and lunch if they did not want to eat on the unit.
- The hospital offered employment opportunities to eligible patients within the hospital grounds.
- The hospital had a recovery college based on site.
- Patients knew how to complain and were supported to do so by staff.
- The provider held quarterly food forums for patients to give feedback about food quality and make suggestions for meal choices.
- Patients could take part in volunteering within the local community.

However:

- Some bedrooms and bathrooms on Elstow 1 and Elstow 2 were cold.
- Patients gave varying reviews about the quality of food provided on the units.

Summary of findings

Are services well-led?

We rated well-led as requires improvement because:

- Although audits of the long-term segregation paperwork were being completed, we found discrepancies in daily review notes. Managers had not ensured staff completed accurate and contemporaneous records for all patients. We found some long-term segregation daily review notes that had been cut and pasted from previous days.
- We received no evidence to suggest that staff received feedback on the outcome of complaints.
- Health care assistants did not feel involved or informed about outcomes from clinical governance meetings.

However:

- Staff were passionate about the client group they were working with and reflected the providers values.
- Overall, 89% of staff had received mandatory training, 76% of staff were receiving regular supervision and 89% of eligible staff had received an appraisal.
- The hospital was taking steps to improve morale and staff retention. The management team had worked towards a cultural shift within the hospital and an opportunity to refresh the workforce, which resulted in a higher than average turnover of staff. The hospital recruited a new team of unit general managers in September 2018, which improved staff morale and has supported with developing leadership within the hospital. Unit general managers felt valued, respected, rewarded and supported.
- The hospital was facilitating a weekly HR surgery for staff. Staff were offered to opportunity to feedback on the hospital and service development through various routes. Staff had access to an external provider offering an employee assistance programme.

Requires improvement

Summary of findings

Information about the service

Lakeside provides care, treatment and support for patients on the autistic spectrum, and support with mental health concerns, anxieties, or learning disabilities. Eight units were open at the time of inspection and there were 42 patients receiving care and treatment. Two of these patients were on section 17 leave. Lakeside is part of Accomplish Group Support Limited and consists of the following wards:

• Elstow 1 unit provides five beds for women. This is a locked rehabilitation unit.

• Elstow 2 unit provides six beds for younger men (18-25 years). This is a locked rehabilitation unit.

• Elstow 3 unit provides nine beds for men. This is a locked rehabilitation unit.

• Elstow 5 unit provides eight beds for men. This is a locked rehabilitation unit for more stable patients stepping down.

• Cooper 1 unit provides seven beds for men. This is a locked male intensive care and admission unit.

• Cooper 2 unit provides seven beds for men. This is a structured assessment unit for adult autistic males in crisis.

• Cooper 3 unit provides four beds for men. This is a behavioural support unit, for patients who require intensive support from staff due to risk behaviours.

• Gifford unit provides 12 beds for women with diagnostic features of Emotionally Unstable Personality Disorder.

At the time of inspection, there was a registered manager and nominated individual in post. 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 hospital changed its name in January 2018. The hospital registered with the Care Quality Commission in 2005. The Care Quality Commission has carried out 10 inspections since the hospital registered in 2005. The last comprehensive inspection was carried out in March 2018. Following the inspection, the Care Quality Commission rated the provider as inadequate overall and the hospital was placed in special measures. We rated safe and effective as inadequate, caring and responsive as requires improvement and well-led as inadequate. In June 2018, the Care Quality Commission undertook a focused, announced inspection to focus on staffing, care planning and therapeutic activities. We found some improvements had been made. Following the June 2018 inspection, we told the hospital that it must take the following actions:

• The provider must ensure staff are competent to manage patients with epilepsy and that care plans detail management of a seizure.

• The provider must ensure that all care plans are person centred and recovery focused, with achievable goals and that records show the rationale for decisions taken in relation to the care and treatment. Records must always be signed and dated by staff and where possible by the patient.

• The provider must ensure that patient involvement is always recorded or the reason for not is recorded. During the current inspection we noted that 88% of staff had received training in managing patients with epilepsy, most care plans were person centred and recovery focused and patient involvement was predominantly recorded.

Summary of findings

Our inspection team

The team that inspected Lakeside consisted of two inspection managers, four CQC inspectors, a Mental Health Act reviewer, and three specialist professional advisors with a background in learning disability and autism.

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?

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 13 patients who were using the service;
- spoke with three carers;
- spoke with the registered manager and managers for each of the wards;
- spoke with 40 other staff members; including nurses, psychologists, health care assistants and housekeeping staff;
- attended and observed a long-term segregation meeting, a multidisciplinary morning meeting and three hub meetings;
- reviewed 32 care and treatment records of patients;
- Looked at 13 staff files;
- 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 provider's services say

We spoke with 13 patients using the service.

- Most patients said staff were good and gave examples of how staff helped them, for example, managing daily living skills such as money budgeting, cooking, cleaning and laundry. One patient on Elstow 1 said staff can sometimes be abrupt, another patient we spoke with on Elstow 1 said staff were not always visible.
- Patients with mobile phones told us they could access the hospital Wi-Fi.
- Patients said they could access the kitchen when required to make drinks or snacks. One patient told us that there was often a long queue to get in to the kitchen if all patients wanted to make a drink or snack at the same time.

Summary of findings

• Patients gave varying reviews about the quality of food provided, all patients we spoke with said the star centre café food was good quality and there was lots of choice. Patients were not as positive about evening meals that were delivered to the units.

• Patients told us they had access to appropriate spiritual support. One patient said they had been taken to church and they could visit the multi-faith room.

• Patients knew how to complain and told us when they had complained, they had received feedback on their complaint.

Good practice

• The Star centre was a finalist at the national learning disability awards 2018 for the 'autism best practice' category.

Areas for improvement

Action the provider MUST take to improve

• 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.

Action the provider SHOULD take to improve

- The provider should ensure all staff receive the same restrictive intervention training.
- The provider should ensure all patients are offered a copy of their care plan.

Accomplish Group Support Limited

Lakeside

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Lakeside Hospital	Lakeside Hospital

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. Staff compliance with Mental Health Act training was 94%. Agency 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 a total of 40 detained patients and two informal patients at the time of our inspection. There were good working relationship between the Mental Health Act administration team and the units, 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.
- 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 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. A senior member of staff told us there were weekly independent mental health advocate drop-in sessions. The independent mental health advocate also visited for specific appointments and meetings with patients. We had an opportunity to speak with the advocate during the inspection who confirmed that patients were referred to the service and seen after admission.
- The independent mental health advocate attended various meetings including multidisciplinary team meetings, First Tier Tribunal meetings, managers hearings, weekly long-term segregation review meetings, 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.
- Some staff we spoke with told us Section 17 leave (permission for patients to leave hospital) could be cancelled if the patient had an incident in the 24 hours leading up to Section 17 leave. We saw a sign displayed on one ward notice board that confirmed this. However,

management told us the sign had been taken from a specific patients care plan and should have not been on display. The sign was promptly removed by management during inspection.

- Patients were not provided with information relating to their section 17 leave. There was a standardised system for recording leave, and leave forms were kept within a section 17 leave file on the unit. There was a space for patients to sign that they had received copies of their leave forms. However, this was left blank on several forms we reviewed. Patients, carers and professionals involved in patients' care were not provided with copies. Staff told us they would undertake a patient risk assessment before leave took place. The hospital had recently developed a post section 17 leave feedback form for staff to complete with patients.
- Informal patients could leave at will, all doors displayed signs, including easy to read.
- Unit 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 the information contained within the census and contacted the unit staff if there were any gaps in the documentation.
- A pharmacist completed monthly audits including the provision of section 58 (treatment requiring consent or a second opinion).

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed e-learning Mental Capacity Act training annually. Staff compliance with Mental Capacity Act training was 98%. Agency staff also attended the providers Mental Capacity Act training.
- There were no deprivation of liberty safeguards 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 regarding the Mental Capacity Act, including deprivation of liberty safeguards.
- The Responsible Clinician assessed patients' capacity to consent to treatment in each of the records we reviewed. However, there were delays with reviewing capacity. On one record, the patient's capacity was last reviewed on 2 October 2017 on a second record capacity was last reviewed on 11 January 2018.
- The hospital had Mental Capacity Act Champions who attended external bi-monthly meetings with specialist Mental Capacity Act leads from Bedford.
- Staff knew where to get advice and support regarding the Mental Capacity Act within the organisation.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The hospital had closed circuit television installed and convex mirrors were in use across site allowing staff to observe all parts of the units.
- 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 unit.
- The provider was compliant with the Department of Health's guidance on the provision of single sex accommodation. All units were single gender.
- Each unit had a fully equipped clinic room, we found no out of date medication. The hospital used an external pharmacy service to audit medication and the clinic rooms weekly. Each unit had access to an emergency resuscitation bag to use in a medical emergency. Emergency resuscitation bags were audited weekly and were secured by tamper seals.
- The hospital employed a team of housekeeping staff who kept the hospital clean and tidy. Areas were visibly clean throughout most of the hospital and cleaning schedules were in place. During inspection we noticed that the environment on Cooper 3 unit was cramped, dark, tired and the floors in the bathrooms and communal areas were dirty. The unit environment did not promote patients recovery. The unit cleaning schedule had not been fully completed for the previous or current week. On the same unit there was a damaged sofa which needed replacing and the kitchen window was leaking, we also noticed that a door containing patient fishing equipment had been left unlocked and a kitchen cupboard containing dishwasher tablets had been left unlocked. The management team told us that Cooper 3 was used as a long-term segregation unit and work to redecorate the unit in line with the hospitals redecoration programme was due to begin in April 2019.
- We noticed a strong smell of drains on the second floor on Elstow 1. Management told us this was an ongoing issue that was being addressed. One patient on Elstow 1 told us the smell was so unpleasant sometimes that she had to leave her room. She had been offered to move rooms but declined.
- Staff adhered to infection control principles. The hospital displayed hand washing posters at each sink. Hand sanitizer was available in all areas, including in clinic rooms and the reception area.
- Staff had access to personal alarms which signalled on panels around the unit where an incident had taken place. The hospital had a bleep holder allocated to each unit who carried a pager to respond to incidents quickly. Nurse call bells were present in all bedrooms. However, on Elstow 2 one patient's nurse call bell was not working, staff were aware that the bell was not working and had raised the issue with the maintenance team.

Safe staffing

- Unit general managers discussed staffing at daily hub meetings and adjusted the daily staffing levels dependant on patient need and additional observations.
- Staff received and were up to date with appropriate mandatory training and the average mandatory training rate for staff was 89%. Mandatory training included health and safety, equality and diversity, Mental Capacity Act and Deprivation of Liberty Safeguards, safeguarding level 2 and Mental Health Act training. Overall, 98% of staff had completed autism awareness training, 88% of staff had completed epilepsy training and 74% of staff had completed diabetes awareness training.
- We looked at staffing rotas for January 2019. The number of nurses present during the inspection matched the staffing rotas and met safe staffing guidelines. The hospital could use agency staff as required.
- Agency nurses were familiar with the unit they were working on. The hospital had recently reduced the agencies it was using to supply staff meaning the same nurses were being used on a more regular basis.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Unit general managers were supernumerary to daily staffing numbers.
- During our visit qualified nurses were present on units 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 units.
- The hospital employed a practice 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.

Assessing and managing risk to patients and staff

- Between May 2018 and November 2018 there were 17 episodes of seclusion. These were highest on Cooper 1.
- The hospital was focussing on reducing restrictive practice. A new role had been developed to take lead on reducing restrictive practice and the provider had improved recording episodes of restraint. Managers had organised a meeting with a company who delivered physical restraint training to discuss the option of training all staff using the same technique. Between May 2018 and November 2018 episodes of restraint had reduced by 26%.
- The provider submitted evidence showing that between May 2018 and November 2018 there were 898 episodes of restraint involving 51 patients. This included 75 episodes of restraint on Ashwood unit which has since closed. The highest number of restraint was 222 occasions on Cooper 3 unit, the behavioural support unit for patients who require intensive support from staff due to risk behaviours.
- Use of physical restraint was separated in to levels of restriction. Between October and December 2018 there were 350 episodes of restraint. Overall, 124 were classified as high restrictive (supine), 240 were classified medium restrictive (holding & escort, seating & kneeling) and 14 were non-restrictive (assault avoidance & redirection). During some episodes of restraint more than one level of restriction was used.
- Between May 2018 and November 2018 there was one record of prone restraint. However, on review of the restraint it had been incorrectly recorded.
- We looked at 32 sets of patient care records across the units. All of them demonstrated that staff assessed risks to patients and themselves. However, some risk assessments did not include patients not having access to bedrooms keys.
- 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 reviewed daily at the morning unit meetings and monthly by the multidisciplinary team.
- On Elstow 2 only one of the four patients on the unit had access to a key for their own room. Staff told us the remaining three patients were at risk of harming or losing their key. There were also some doors on the unit which were locked on the day of the inspection which patients did not have access to. The dining room was locked as were the doors from the dining room to the courtyard. This was not indicated in patients' individual risk assessments or care plans to clearly justify this level of restriction.
- Informal patients could leave at will and all doors displayed signs, including in easy to read versions.
- At the time of inspection there were four patients in long-term segregation on Cooper 3 unit. Each patient had their own bedroom and lounge area and access to a communal outdoors space. Managers notified the safeguarding team of all long-term segregations. The average length of stay for patients on Cooper 3 was one year, one patient had been residing on Cooper 3 for one year and nine months. Attempts had been made to reintegrate patients to other units within the hospital or to other suitable hospital placements.
- Three monthly independent reviews by an external hospital were not being carried out for patients in long-term segregation. Attempts had been made for independent reviews to take place. However, these had

been unsuccessful. The hospital invited the patients' external commissioners and case managers to attend quarterly review meetings together with the IMHA being present.

- The provider had policies and procedures for use of observation and searching patients. Staff only searched patients where indicated by risk.
- The provider's observation policy did not follow National Institute for Health and Care Excellence guidance on violence and aggression: short-term management in mental health, health and community settings. We saw team meeting minutes dated 12 January 2019 which showed one staff member was observing the same patient for five hours. Staff told us they routinely spent longer than two hours observing the same patient and they frequently spent a working day carrying out observations on patients.
- Staff told us they only used restraint after de-escalation had failed and using correct techniques. Overall, 81% of staff were trained in physical intervention. The provider advised us there was an issue with physical restraint training as permanent staff were trained using a different technique to agency staff. Managers had a meeting organised with a company who delivered physical restraint training to discuss the option of training all staff using the same technique. Using different techniques could pose a risk to staff and patients if staff were following two different approaches.
- Staff were not routinely completing rapid tranquilisation medicine protocol evaluation forms. We saw a patient on Gifford unit who was administered 50mg promethazine on 15 January 2019 at 22:00 and then again at 13:30 on 16 January 2019, this is more than recommended within National Institute for Health and Care Excellence guidance. We also found another patient on Gifford who had been prescribed 'as needed' lorazepam on several occasions but the monitoring had not been completed.
- Between October 2018 and December 2018 there were 20 occasions of rapid tranquilisation. The highest use of rapid tranquilisation was 16 occasions on Cooper 2. Between October 2018 and December 2018, the use of rapid tranquilisation had reduced by 26%.
- The seclusion room had a window, offering natural light, with an electronically operated blind. Staff could control the temperature of the room. There was a clock within eyesight of the patient. There was an ensuite area, providing a toilet, hand-basin and shower. Staff could have two-way communication with the patient using an intercom. However, whilst showing us the seclusion facilities, staff made several attempts to operate the intercom before they could operate it effectively. We were concerned this may potentially cause a patient further distress. We raised these issues to the attention of the unit general manager in charge of overseeing the seclusion facilities.
- We found long term segregation daily review notes that had been cut and pasted from previous days. We saw four records for three patients located on Cooper 3 that had been duplicated throughout January 2019. This was immediately addressed by the management team and an investigation was carried out to ensure processes were more robust.
- Staff were trained in safeguarding and knew how to make a safeguarding alert. Overall, 87% of staff had completed safeguarding level 2 training. The hospital had access to an internal safeguarding lead.
- 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.
- There were procedures in place for children to visit the hospital. There was a family visiting room located within the star centre.

Track record on safety

- The hospital reported one serious Incident between December 2017 and November 2018 where a patient had managed to climb out a window on the ground floor. Since this incident the provider had changed the windows throughout the hospital.

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.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Staff reported all incidents that should be reported. Incidents were logged on to the computerised incident 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.
- Staff received feedback from investigation of internal incidents through the clinical governance reports, daily hub meetings and team meetings.
- Managers fed back learning from incidents and areas of good practice in daily hub meetings and team meetings.
- There were no written records showing that staff had debriefed with managers. The head of therapies was running bi-monthly reflective practice sessions which were open to all staff. We saw minutes of these meetings taking place.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at 32 sets of care and treatment records. Staff assessed the physical and mental health of patients within 48 hours of admission. One patient record did not include a physical health check, staff told us the patient refused to have their physical health checked on admission but this decision was not recorded.
- Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were personalised, holistic and recovery-orientated. Staff completed individualised positive behavioural support plans for patients which contained proactive and reactive strategies for a range of patient specific triggers and early warning signs in relation to behaviour and presentation. Care plans were also completed in easy read.
- We looked at 32 physical health care plans. One patient on Elstow 1 still had lithium as an active care plan goal. This patient was taken off lithium in September 2018 and the care plan had not been updated to reflect this. One patient on Gifford unit did not have a care plan relating to her asthma. A care plan for a patient on Elstow 5 stated that the patient should always have his inhaler whilst accessing the community but we found that he was on leave for the day during inspection and had not taken his inhaler with him.

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. The therapy team had the autonomy to adapt and deliver groups or one to one sessions dependant on client need and had recently started running groups on units to encourage patient engagement. The head of therapies had recently audited patient engagement in activities and an improvement in attendance had been noted.
- We reviewed 32 prescription records. Staff followed National Institute for Health and Care Excellence guidance when prescribing medication. Antipsychotic medication was prescribed within the British National Formulary limits.
- The hospital employed a practice 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 smoking cessation clinics for patients and health promotion groups including health and hygiene, healthy eating and physical activity and mental health. Patients were offered cervical screening tests with the practice nurse.
- The hospital invited a specialist dentist to attend the hospital every two weeks to support with dental care.
- Staff completed assessments of nutrition and hydration and care plans were in place for specific patients.
- 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.

Skilled staff to deliver care

- The provider employed a therapeutic services team which included doctors, clinical psychologists, assistant psychologists, occupational therapists and occupational therapy assistants, a recovery college lead, therapy assistants and an art therapist. At the time of inspection, the hospital had a vacancy for a speech and language therapist (SALT). A qualified speech and language therapist was supervising and supporting a SALT assistant carrying out low levels of intervention for patients who had difficulties with communication, eating, drinking and swallowing.
- The hospital had access to an ad hoc speech and language therapist to offer additional support as required. Patients had access to a GP weekly and a practice nurse who worked at the hospital full time. A pharmacist 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. Staff then had a week where they shadowed on their allocated unit and underwent competency assessments.

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- The percentage of staff that had had an appraisal in the last 12 months was 89%.
- The percentage of staff that received regular supervision was 76% in December 2018. The highest number of supervision in December 2018 was Cooper 3 with 93% completion.
- 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 autism awareness and epilepsy training. Staff told us they could request additional training during supervision.
- Managers dealt with poor staff performance promptly and effectively during supervision. Staff suspensions were discussed at monthly clinical governance meetings.

Multi-disciplinary and inter-agency team work

- The hospital held a variety of staff meetings, including monthly clinical governance meetings and monthly senior healthcare meetings. The head of therapies was running bi-monthly reflective practise sessions which were open to all staff. The hospital provided additional staff on those days to ensure staff could attend.
- Staff held daily unit meetings which then fed into the morning meeting with senior managers.
- Managers reported relationships had improved with the local authority safeguarding team, local residents and the parish council. Nursing staff invited community care coordinators and commissioners to multidisciplinary meetings and reviews. The provider recently held an engagement day for professionals to attend to show improvements made within the hospital.

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

- Staff completed mandatory face-to-face Mental Health Act training annually. Staff compliance with Mental Health Act training was 94%. Agency 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 a total of 40 detained patients and two informal patients at the time of our inspection. There were good working relationship between the Mental Health Act administration team and the units, 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.
- 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 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. A senior member of staff told us there were weekly independent mental health advocate 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, weekly long-term seclusion review meetings, 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 (permission for patients to leave hospital) could be cancelled if the patient had an incident in the 24 hours leading up to Section 17 leave. We saw a sign displayed on one ward notice board that confirmed this. However, management told us the sign had been taken from a specific patients care plan and should have not been on display. The sign was promptly removed by management during inspection.
- Patients' records did not demonstrate they were provided with information relating to their section 17

  leave. There was a standardised system for recording leave and leave forms were kept within a section 17 leave file on the unit. There was a space for patients to sign that they had received copies of their leave forms, however this was left blank on several forms we

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reviewed. Carers and professionals involved in patient's care were also not provided with copies. Staff told us they would undertake a patient risk assessment before leave took place. The hospital had recently developed a post section 17 leave feedback form for staff to complete with patients.

- Informal patients could leave at will, all doors displayed signs, including easy to read.
- Unit 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 the information contained within the census and contacted the unit staff if there were any gaps in the documentation.
- A pharmacist completed monthly audits including the provision of section 58 (treatment requiring consent or a second opinion).

Good practice in applying the Mental Capacity Act

- Staff completed E Learning Mental Capacity Act training annually. The staff compliance with Mental Capacity Act training was 98%. Agency staff also attended the providers Mental Capacity Act training.
- There were no deprivation of liberty safeguards 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 assessed patients' capacity to consent to treatment, in each of the records we reviewed. However, there were delays with reviewing capacity. On one record, the patient's capacity was last reviewed on 2 October 2017 on a second record capacity was last reviewed on 11 January 2018.
- The hospital had Mental Capacity Act Champions who attended external bi-monthly meetings with specialist Mental Capacity Act leads from Bedford.
- Staff knew where to get advice and support regarding the Mental Capacity Act within the organisation.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed staff treating patients with kindness, dignity and respect. This was confirmed by most patients. One patient on Elstow 1 said staff can sometimes be abrupt, another patient we spoke with on Elstow 1 said staff were not always visible.
- We saw a number of caring interactions between staff and patients. We saw staff knocking on patients' doors and staff on Cooper 1 supporting a patient who was experiencing some distress in a calm and attentive manner.
- Patients gave examples of how staff helped them, for example managing daily living skills such as money budgeting, cooking, cleaning and laundry. Patients with phones told us they could access the hospital Wi-Fi.
- Patients had access to an independent mental health advocate who regularly visited the hospital.
- Staff had a good understanding of individual needs of patients and their positive behavioural support plans.

The involvement of people in the care that they receive

- On admission, staff gave patients a welcome pack with information about the hospital, which explained catering, activities, and treatment. Staff orientated patients to the unit and hospital as part of the admission process.
- Care and treatment records demonstrated that patients had been involved in their care plans, some patients confirmed this. We looked at 32 care and treatment plans, nine patients had not received a copy of their care plan which equated to 28%.
- Managers had identified a need for increasing family members engagement in treatment. Due to the high number of out of area placements family forums were not well attended. The hospital had introduced a webcam system for family members to attend meetings.
- Staff told us there were carers champions on the unit. They were making plans to set up carer's involvement groups, but they had not yet been organised. These groups had taken place in the past and at that time there was poor patient and carer engagement. The previous carer's forum was held in July 2017.
- We saw evidence on patients' files that all patients were asked if they wished to have carers or relatives involved in discussions about their care or to be given information about them from unit staff.
- With the patient's consent, relatives and carers were invited to care programme approach meetings.
- We spoke with three carers of patients. Two carers were positive about the care their family member was receiving. All carers said they were invited to multidisciplinary meetings. However, one carer told us they did not feel properly updated about their family members care. One carer we spoke with said the hospital had recently improved, staff were friendly and communication had improved.
- Patients could feedback on the service they received. The hospital completed a patient survey in June 2018 which 62% of patients took part in, patients completed the survey with support from the independent mental health advocate. Overall, 100% of patients who answered the survey said they could contact their family and friends and 100% said their friends and family had the opportunity to visit. Patients could attend unit patient forum meetings.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The Hospital was changing their care pathways to support patients with learning disabilities to live in the community with appropriate support and services. However, 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.
- average length of stay for patients who had been discharged in the 12 months leading up to inspection was one year and nine months, the longest length of stay was thirteen years on Cooper 2 unit.
- Average bed occupancy between August 2018 and January 2019 was 66%. At the time of inspection there were 40 patients receiving care and treatment and two patients on section 17 leave.
- Due to the specialist nature of the hospital most patients were from out-of-area placements.
- Patients were not moved between units 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 or care co-ordinators. Patients we spoke with confirmed they were involved in their discharge planning.
- Staff supported patients to access external appointments including acute hospital appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients could personalise their bedrooms. We saw bedrooms with pictures and patients' own rugs, one patient we spoke with said his bedroom was cosy and staff helped to make his bedroom feel homely. Overall, 81% of patients who completed the patient survey in June 2018 said they were happy with their bedrooms.
- Some bedrooms and bathrooms on Elstow 1 and Elstow 2 were cold. We saw staff wearing coats, hats and scarves whilst observing a patient on enhanced observations. One patient we spoke with said they were told new radiators were going to be installed. Managers told us that heating maintenance was underway.
- Patients could store their possessions securely in a safe in their bedrooms.
- Across the units, patients had access to a lounge area with appropriate furniture, a TV, music and games. The therapy centre, known as the star centre, was in a separate building from the units. The star centre was a multi-functional space for therapy groups and leisure activities, there was also a family visiting room, art therapy room a café and a gym. Patients could access the star centre for freshly made breakfast and lunch if they did not want to eat on the unit.
- Patients were permitted use of a ward 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.
- All patients had access to enclosed outdoor space.
- Patients gave varying reviews about the quality of food provided, all patients said the star centre café food was good quality and there was lots of choice. Patients were not as positive about evening meals that were delivered to the units. Overall, 69% of patients who completed the patient survey in June 2018 said they liked the food available. One patient told us that sometimes evening meals were not served straight away and were cold by the time they started eating. The provider held quarterly food forums for patients to give feedback about food quality and make suggestions for meal choices.
- Staff kept the kitchen areas locked on each of the units. Patients we spoke with said they could access the kitchen when required to make drinks or snacks. One patient told us that there was often a long queue to get in to the kitchen if all patients wanted to make a drink or snack at the same time.
- The hospital offered employment opportunities to eligible patients within the hospital grounds, roles included kitchen assistant at the star centre, assistant groundskeeper, tuck shop assistant and chairperson of patient forum meetings.
- Patients could take part in volunteering within the local community.

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- The hospital had a recovery college on site, with courses including health and wellbeing, functional skills, coping skills, practical community skills and vocational qualifications. The recovery college was open to all patients within the hospital.

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 units. 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 a welcome pack on admission.
- Leaflets and information was available in other languages for patients for whose first language was not English. Information was also available in easy read format. Staff told us patients could access an interpreter if required.
- The hospital catered for all dietary and religious requirements.
- Patients told us they had access to appropriate spiritual support. One patient said they had been taken to church and they could visit the multi-faith room.

Listening to and learning from concerns and complaints

- The hospital received 33 complaints between December 2017 and November 2018. The highest number of complaints were from patients residing on Elstow 1, Cooper 1 and Cooper 2. Overall, seven complaints were upheld and none were referred to the ombudsmen.
- Patients knew how to complain and were supported to do so by staff. Patients told us when they had complained, they had received feedback. Results from the annual patient's survey showed that 75% of patients felt they received enough support to resolve their complaint.
- Staff we spoke with knew how to manage patient complaints.
- We received no evidence to suggest that staff received feedback on the outcome of complaints. However, managers investigated complaints appropriately.
- The hospital received 16 compliments between December 2017 and November 2018. Compliments were mostly from teams outside the organisation, two were from patients' family members.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff were aware of the provider's visions and values which were displayed in reception and on office notice boards. Accomplish values were quality, celebrate uniqueness, fun, brave and move mountains.
- Staff were passionate about the client group they were working with and reflected the providers values.
- Staff knew who senior managers were within the hospital and said they visited units daily.

Good governance

- Overall, 89% of staff had received mandatory training, 76% of staff were receiving regular supervision and 89% of eligible staff had received an appraisal.
- Staff carried out audits across the hospital, these included a monthly long-term segregation audit, a twice yearly patient file audit and a personal emergency evacuation plan audit for individuals who may not be able to reach an ultimate place of safety unaided in the event of an emergency. Staff carried out further audits on a selection of topics including an ingesting and choking audit, epilepsy audit, dysphagia (swallowing difficulties) audit, an absconding audit and a sleep apnea audit. Results from audits were collated, fed back and discussed at the monthly clinical governance meetings. Feedback from clinical governance meetings were cascaded to unit general managers. Health care assistants told us they received feedback about incidents via team meetings and from their managers but did not feel informed about outcomes from clinical governance meetings.
- Audits for long-term segregation daily review notes had not been completed comprehensively. We found long-term segregation daily review notes that had been cut and pasted from previous days. We saw four records for three patients located on Cooper 3 that had been duplicated throughout January 2019. This was immediately addressed by the management team and an investigation was carried out to ensure processes were more robust.
- The hospital had 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 unit staff were alerted to these lessons learnt and recommendations immediately.
- Managers investigated complaints in a timely manner and fed back the findings to patients. However, we received no evidence to suggest that staff received feedback on the outcome of complaints.
- 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.
- Unit general managers felt they had sufficient authority and administrative support to carry out their roles.
- Unit general managers had a clear oversight of the staffing on their units, including staff training, staff performance and developmental needs.

Leadership, morale and staff engagement

- The hospital had recently completed a you said / we hear you exercise with staff to anonymously raise any concerns or make recommendations to improve the service. The management team had completed a draft response to staff at the time of inspection. We saw staff suggestions being taken into consideration including the possibility of health care assistants being invited to multidisciplinary team meetings.
- 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.
- The hospital recruited a new team of unit general managers in September 2018, which improved staff morale and supported with developing leadership within the hospital. A deputy unit general manager position had also been appointed to offer cover for sickness and annual leave.
- The hospital had a speak up guardian who was recruited by staff and was publicised across the hospital.
- Between January 2018 and January 2019, 132 staff members left the hospital, this equated to 46.6% of the

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workforce. During October and December 2018, 35 staff members left. All staff leavers completed an exit interview. Lakeside had recently completed a recruitment campaign and were at full complement for health care assistants.

- The management team explained they had worked hard to achieve a cultural shift within the hospital and an opportunity to refresh the workforce, which resulted in a higher than average turnover of staff. Staff told us there had been improvements made within the last year and they enjoyed working at Lakeside over recent months.
- 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.
- The provider had recently developed and implemented a new sickness / absence policy to take positive action on monitoring staff sickness levels. In the 12 months leading up to inspection the provider reported a 3.98% sickness rate. Staff received a return to work interview when they returned from a period of absence.
- Staff knew how to use the providers whistle-blowing process. The hospital also had an anonymised email that staff could submit any concerns or complaints to.
- Staff felt able to raise concerns without fear of victimisation.
- Most staff we spoke with enjoyed their roles and said they had good job satisfaction and a sense of empowerment. However, healthcare assistants told us they would feel more valued if they were informed about outcomes from clinical governance meetings.
- Unit general managers felt valued, respected, rewarded and supported. Unit general managers had attended management and leadership training. Senior healthcare assistants told us they had attended supervision training to support them in supervising health care assistants.
- We observed team working and mutual support between staff members working on the units, there were positive working relationships between unit staff and the therapeutic services team.
- Staff were offered the opportunity to feedback on the hospital and service development through team meetings, the anonymous email service, you said / we heard you improvement suggestions, the HR surgery and suggestions boxes. Managers told us they were hoping to start monthly staff forums and were recruiting a lead role for this position during our inspection.

Commitment to quality improvement and innovation

- The provider had adopted the STOMP health care pledge on two units with a view to all other units taking part. 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. At the time of inspection, the provider was undertaking a review with the patient group.
- The Star centre was a finalist at the national learning disability awards 2018 for the 'autism best practice' category.
- 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Patients records did not demonstrate they were provided with information relating to their section 17 leave.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • Staff did not regularly review patients' capacity to consent to treatment in a timely manner.

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 • Physical health care plans did not reflect patients' current needs and were not being adhered to. • The accommodation and environment on some units was not appropriate for use. • Staff were not routinely completing rapid tranquilisation medicine protocol evaluation forms. • The providers observation policy did not follow National Institute for Health and Care Excellence guidance on violence and aggression: short-term management in mental health, health and community settings.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • We found restrictions on patients' liberty and other rights, without individual risk assessments to justify their application.
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 • We found long term segregation daily records that had been duplicated from the previous day. • Three monthly independent reviews by an external hospital were not being carried out.