Inadequate

Nottinghamshire Healthcare NHS Foundation Trust

High secure hospitals

Quality Report

Rampton Hospital
Retford
DN22 0PD
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Website: www.nottinghamshirehealthcare.nhs.uk

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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)
RHA04	Rampton Hospital	Coral ward	DN22 0PD
RHA04	Rampton Hospital	Emerald ward	DN22 0PD
RHA04	Rampton Hospital	Jade ward	DN22 0PD
RHA04	Rampton Hospital	Ruby ward	DN22 0PD
RHA04	Rampton Hospital	Topaz ward	DN22 0PD
RHA04	Rampton Hospital	Aintree ward	DN22 0PD
RHA04	Rampton Hospital	Cheltenham ward	DN22 0PD
RHA04	Rampton Hospital	Kempton ward	DN22 0PD
RHA04	Rampton Hospital	Newmarket ward	DN22 0PD
RHA04	Rampton Hospital	Grampian ward	DN22 0PD
RHA04	Rampton Hospital	Adwick ward	DN22 0PD
RHA04	Rampton Hospital	Alford ward	DN22 0PD
RHA04	Rampton Hospital	Blake ward	DN22 0PD

Summary of findings

RHA04	Rampton Hospital	Bonnard ward	DN22 0PD
RHA04	Rampton Hospital	Burne ward	DN22 0PD
RHA04	Rampton Hospital	Cambridge ward	DN22 0PD
RHA04	Rampton Hospital	Canterbury ward	DN22 0PD
RHA04	Rampton Hospital	Erskine ward	DN22 0PD
RHA04	Rampton Hospital	Eden ward	DN22 0PD
RHA04	Rampton Hospital	Brecon ward	DN22 0PD
RHA04	Rampton Hospital	Cheviot ward	DN22 0PD
RHA04	Rampton Hospital	Cotswold ward	DN22 0PD
RHA04	Rampton Hospital	Hambleton ward	DN22 0PD
RHA04	Rampton Hospital	Malvern ward	DN22 0PD
RHA04	Rampton Hospital	Quantock ward	DN22 0PD

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Foundation Trust. 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 Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

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

We undertook this inspection to see if the trust had made improvements since our comprehensive inspection in July 2019. This was a focused inspection, we did not inspect all key lines of enquiry and did not rerate. The ratings from the comprehensive inspection in July remain.

- The service continued to not have enough nursing and medical staff. To maintain safety, staff were moved between wards, sent as escorts off the ward, worked additional hours and went without breaks. This impacted on relational security, the quality of patient and staff experience, access to patient activities and access to fresh air. Relational security is the knowledge and understanding staff have of patients and the environment, and the translation of that information into appropriate responses and care. Caseloads of social workers, psychologists and occupational therapists were high in comparison to other high secure hospitals. This prevented them carrying out all aspects of their role.
- Instances of lone working at night continued, which posed a risk should an emergency occur in a bedroom as three staff were required to go in.
- Not all staff were aware of what and where ligature assessments for the ward they were working on were kept or whether accurate records were kept of the maintenance of ligature cutters.
- Staff did not always respond to alarm calls promptly when incidents occurred. Staff continued to say they did not always report incidents or have time to write them up in detail.
- Staff continued to be inconsistent in following the observational policy when recording observations. Staff continued to report they did not always receive breaks from continuous observations.
- We found issues with the storage of medication such as a lack of stock rotation for supplementary medications. Staff did not consistently sign to record patients had received medication or follow National Institute for Health and Care Excellence guidance in reviewing the effects of medication when using intramuscular injection medication.
- Staff did not receive effective handovers that included information about patient risks when they moved wards.
- Staff did not consistently accurately record long term segregation on the electronic patient record.
- Ward staff did not have adequate physical health care training and reported that the quality of clinical supervision was poor.
- Patients continued to raise issues of inappropriate language, racist attitudes by staff and that their privacy and dignity was not respected and confidentially was not maintained by staff.
- The hospital culture required improvement. Staff continued to report that they did not feel able to speak up about concerns without fear of retribution and morale was poor in some areas.
- Governance systems did not operate effectively enough to manage or monitor the impact of staff shortages. In addition to this, there was a lack of consistent, effective recording of shortages or loans to other wards.

However:

- The Rampton hospital implementation board had developed an action plan and we saw evidence that actions were being implemented.
- Management changes across the trust and at Rampton hospital had started to occur and were welcomed by staff and medical consultants, although it was too soon to evaluate the impact.
- All wards were safe, clean, and fit for purpose. Staff followed the infection control policy including hand hygiene.
- Staff assessed the physical and mental health of all patients on admission. Staff completed risk assessments on admission and updated these regularly. They developed personalised individual care plans. They included specific safety and security arrangements and a positive behavioural support plan. Staff used recognised rating scales to assess and record severity and outcomes.
- The ward staff participated in the provider's restrictive interventions reduction programme. Mechanical restraint was used with a clear rationale and with individualised care plans.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Summary of findings

- The service had access to a full range of specialists to meet the needs of the patients on the wards.

Summary of findings

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

Are services safe?

Inadequate

This was a focused inspection, we did not inspect all key lines of enquiry and did not rerate.

- The service continued to not have enough nursing and medical staff. To maintain safety, staff were moved between wards, sent as escorts off the ward, worked additional hours and went without breaks. This impacted on relational security, the quality of patient and staff experience, patient activities and access to fresh air.
- Instances of lone working at night continued, which posed a risk should an emergency occur in a bedroom as three staff were required to go in.
- Not all staff were aware of what and where ligature assessments for the ward they were working on were kept or whether accurate records were kept for the maintenance of ligature cutters.
- Caseloads of social workers, psychologists and occupational therapists were high in comparison to other high secure hospitals. This prevented these staff members from carrying out all aspects of their role.
- Staff did not always respond to alarm calls promptly when incidents occurred. When two alarms were activated at the same time there was a delay in response. Staff shortages also caused delays in responding to alarms.
- Staff continued to say they did not always report incidents or have time to write them up in detail. Staff remained concerned about managers' reactions to reporting staff shortages.
- Staff continued to be inconsistent in following the observational policy when recording observations. Staff continued to report they did not always receive breaks from continuous observations.
- There continued to be lack of consistency in signing medication charts to show medication given. Medicines were not stored at the correct temperature and actions taken in maintaining continued viability of the medicines. Stock rotation of medicines stored in the supplementary cupboard did not occur regularly. Out of date stock items were not always removed. Staff did not follow National Institute for Health and Care Excellence guidance in reviewing the effects of medication when using intramuscular injection medication for managing violence and aggression.

Summary of findings

- There was lack of consistency in using warning flag alerts across different IT systems, and not all staff had access to the various patient electronic systems for physical health.

However:

- All wards were safe, clean, and fit for purpose. Staff maintained equipment well and kept it clean. Staff followed the infection control policy including hand hygiene.
- Staff completed risk assessments on admission and updated these regularly.
- Staff had the skills required to develop and implement good positive behaviour support plans. The ward staff participated in the provider's restrictive interventions reduction programme.
- Mechanical restraint was used with a clear rationale and with individualised care plans.
- 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.
- The service used systems and processes to safely prescribe and administer medication.

Are services effective?

Requires improvement

This was a focused inspection, we did not inspect all key lines of enquiry and did not rerate.

- Not all patients were given access to their care plans.
- Staff did not receive effective handovers that included patient risks consistently when they moved wards.
- There was a lack of consistent recording and filing of long term segregation on the electronic patient record.
- Ward staff did not have adequate physical health care training. Staff did not clearly understand the function, referral process and availability of the physical health centre and the team's responsibility. Staff did not make sure actions following audits of the National Early Warning Score were completed.
- Staff reported that the quality of clinical supervision was not always good and that they recorded having had clinical supervision when they had not, due to staffing and workload pressures.

However:

Summary of findings

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans. Care plans reflected the assessed needs, were personalised. They included specific safety and security arrangements and a positive behavioural support plan.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Are services caring?

Requires improvement

This was a focused inspection, we did not inspect all key lines of enquiry and did not rerate.

- Patients continued to raise issues of inappropriate language and racist attitudes by staff.
- Patients reported that patient information was not kept confidential by staff in communal ward areas.
- Patients reported that they did not feel their privacy and dignity was respected when showering as there were two showers located next to each other, separated by a partition wall, on the men's mental health wards.

However:

- The majority of staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The service had access to a full range of specialists to meet the needs of the patients on the wards.

Are services responsive to people's needs?

Requires improvement

This was a focused inspection and we did not inspect this domain.

Are services well-led?

Inadequate

This was a focused inspection, we did not inspect all key lines of enquiry and did not rerate.

- Staff continued to report that they did not feel able to speak up about concerns without fear of retribtion. Morale continued to be poor in some areas. Not all incidents were reported due to fear and workload pressures.
- Governance systems did not operate effectively enough to manage staff shortages. There was a lack of consistent recording of shortages or loans to other wards. The governance processes were not effective in monitoring the impact of staff shortages on the quality of the patient and staff experience.

Summary of findings

However:

- There was a Rampton hospital implementation board and action plan established. Actions were being implemented, although it was too soon to evaluate the impact. This board reported directly to the trust board and was chaired by the chief executive.
- Management changes across the trust and at Rampton hospital had started to occur and were welcomed by staff and medical consultants, although it was too soon to evaluate the impact.

Summary of findings

Information about the service

Rampton hospital is one of three high secure hospitals in England and is managed by Nottinghamshire Healthcare NHS Foundation Trust. The hospital providers five clinical services, three of which are national services. NHS England is responsible for the specialist commissioning of services in all high secure hospitals. Rampton hospital offers services to patients who suffer from mental disorder and have dangerous, violent or criminal tendencies. All patients admitted to the hospital are detained under the Mental Health Act 1983. Patients also had a diagnosis of a learning disability, mental illness or a psychopathic disorder.

The hospital is required to follow Department of Health and Social Care Guidance on the High Security Psychiatric Services (Arrangements for Safety and Security) Directions (June 2019). Providers of high secure services must comply with certain aspects of this guidance and have discretion about other aspects, for example, night time confinement. Night time confinement is when patients are locked in their bedrooms at night.

Since April 2017 the number of beds at the hospital has reduced from 357 to 322, following national commissioning decisions about beds for patients with personality disorder. At the time of inspection there were279 patients across 25 wards with an additional 19 patients on trial leave. The hospital employed 1277 substantive whole-time equivalent staff (as of October 2019). The annual budget was £94 million.

The hospital has five care pathways; mental health, personality disorder, learning disability, women's and deaf service. The management and leadership structures at the top of each care pathway report to one operational manager who oversees all the ward staff.

Rampton hospital provides the following services:

National high secure women's service with 50 beds:

- Coral (intensive care- six beds)
- Emerald (learning disability and intensive care- six beds)
- Jade (mental illness- 12 beds)
- Ruby (personality disorder- 14 beds)
- Topaz (personality disorder admission ward- 12 beds)

National high secure learning disability service with 52 beds for men:

- Aintree (positive behaviour therapy ward- 13 beds)
- Cheltenham (assessment and admission ward- 14 beds)
- Kempton (physical healthcare/positive behaviour therapy ward- 14 beds)
- Newmarket (therapeutic community- 11 beds)

National high secure deaf service with 10 beds for men:

- Grampian ward- 10 beds.

Mental health service with 134 beds for men:

- Adwick (intensive care- 10 beds)
- Alford (continuing care and treatment- 16 beds)
- Blake (admission and treatment- 16 beds)
- Bonnard (admission and treatment- 16 beds)
- Burne (admission and treatment- 16 beds)
- Cambridge (pre-discharge and physical healthcare- 20 beds)
- Canterbury (rehabilitation and pre-discharge- 20 beds)
- Erskine ward (admission and treatment- 20 beds).

Regional personality disorder service 76 beds for men:

- Eden (personality disorder treatment- 18 beds)
- Brecon (high dependency- 10 beds)
- Cheviot (admission and assessment- 8 beds)
- Cotswold (treatment- 10 beds)
- Hambleton (treatment- 10 beds)
- Malvern (treatment- 10 beds)
- Quantock (treatment- 10 beds).

Summary of findings

Our inspection team

The team that inspected Rampton hospital consisted of one head of hospital inspection, two CQC inspection managers, six CQC inspectors, three Mental Health Act reviewers, one CQC medicines team inspector and six specialist advisors with experience of working in forensic services. The specialist advisors included a psychiatrist, an occupational therapist, one mental health nurse with a specialism in physical health, one learning disability nurse, two mental health nurses and one expert by experience. An expert by experience is someone who has used mental health services.

Why we carried out this inspection

We undertook a focussed inspection to see if the trust had made improvements following the comprehensive inspection in July 2019.

Previous inspections and monitoring

The Care Quality Commission undertook a focused inspection of four wards at Rampton hospital in March and April 2016 following concerns about staff not carrying out observations of patients correctly. Following that inspection, we issued a warning notice on this issue. A follow up inspection in August 2016 found that the hospital had made improvements. We completed a comprehensive inspection of Rampton hospital in March 2017 and rated it as requires improvement overall (safe, effective and responsive as requires improvement, well led as inadequate and caring as good).

We inspected Rampton hospital in March 2018 and rated it overall as requires improvement. Safe and responsive were rated as requires improvement and effective caring and well led were rated as good.

In June 2019, we completed a review of the seclusion and long-term segregation at Rampton hospital as part of a national review of these practices.

We carried out a comprehensive inspection in July 2019 and rated Rampton hospital as inadequate overall. Safe and well led were rated as inadequate and effective, caring and responsive as requires improvement. Following the inspection, we said that:

- The hospital must ensure there is adequate staffing across the hospital to facilitate on and off ward activities, ground leave and, access to fresh air and to reduce the frequent movement of staff during shifts to other wards. Regulation 18 HSCA (RA) Regulations 2014 Staffing.
- The hospital must ensure that the system that records the amount of activities that patients engage in is accurate and this is used effectively by staff. Regulation 17 HSCA (RA) Regulations 2014, Good governance.
- The hospital must ensure staff feel confident and are competent to implement physical healthcare plans effectively. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital must ensure National Early Warning Scores are completed accurately and acted upon in line with national guidelines. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital must ensure that all medication is signed for and medicines are not stored or used after their expiry date. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital must ensure that all staff adhere to the trust's observation policy when conducting and recording observations. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital must ensure recording of seclusion and long-term segregation reviews are undertaken in accordance with the Mental Health Act Code of Practice. Regulation 13 HSCA (RA) Regulations 2014, Safeguarding.
- The hospital must ensure staff have sufficient time and are supported to report incidents accurately. Regulation 17 HSCA (RA) Regulations 2014, Good governance.
- The hospital must take steps to investigate how widespread is the use of racist language and other inappropriate language by staff towards patients and stop this. Regulation 13 HSCA (RA) Regulations 2014, Safeguarding.

Summary of findings

Following our comprehensive inspection in July 2019 a multiagency risk review took place. We have completed enhanced monitoring with the provider to review the actions put in place to address our concerns.

How we carried out this inspection

During our inspection on 13 and 14 November 2019 we:

- spoke with 89 staff individually and an additional 75 staff members attended our focus groups to share their experience of working in the hospital
- our physical health team spoke with 21 staff
- our physical health team spoke with seven patients
- spoke with 62 patients
- looked at the care and treatment records of 30 patients across the hospital
- looked at the medication charts for 37 patients
- looked at nine seclusion records
- looked at seven records of patients detailing the use of mechanical restraint
- observed four multidisciplinary team meetings, including ward round reviews and a Care Programme Approach review meeting
- visited the central resource office to review data about staff movement across the hospital
- obtained information from specialised commissioners.

What people who use the provider's services say

Some patients said they did not feel safe, citing shortages of staff as the main reason.

Seventeen patients (27% of total patients spoken with) reported issues with activities being cancelled due to staffing pressures.

Eight patients reported staff shortages affected access to fresh air.

There was mixed feedback about the suitability of activities across the trust. Patients from the learning disability service were very positive about the activities offered.

Six patients reported concerns about staff attitude. A minority of patients said that they did not feel confident to raise racist behaviour to staff. Some patients raised issues about a bullying culture on wards.

Patients on the mental health wards raised issues with food, describing it as cold which they did not want to eat, and no alternative was offered when they reported this.

Three patients reported issues with access to family visits and three reported good access to family visits.

Five patients did not feel involved in care plans, and four did.

Seven patients knew how to complain, and one did not.

Five patients reported issues with access to one to one time with their named nurse, four reported having access to their named nurse.

Nine patients reported physical health care as good, three reported issues with physical health care.

Four patients were well informed about the use of physical restraint and the reasons for its use.

Three patients (two of whom were in mechanical restraint) said that they felt contained by it. They all said they preferred it to physical restraint that involved being touched by staff. Patients described it as being too tight, humiliating and degrading.

Patients said they had access to an advocate.

Patients on the learning disability, deaf, and women's wards reported they felt respected and valued and listened to.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure there is adequate staffing across the hospital to keep patients safe and meet their needs, including ensuring social workers, psychologists and occupational therapists are able to meet the needs of all patients in their care. Regulation 18 HSCA (RA) Regulations 2014, Staffing.
- The trust must ensure staff report all incidents required accurately and in a timely manner. Regulation 17 HSCA (RA) Regulation 2014, Good governance .
- The trust must ensure that safe and consistent processes are used to support patient's physical health care requirements in line with the trust policy. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment
- The trust must ensure that all staff adhere to the trust's observation policy when conducting and recording observations. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The trust must ensure staff follow National Institute for Health and Care Excellence guidance in reviewing the effects of medication when using intramuscular injection medication for managing violence and aggression. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The trust must ensure staff receive effective handovers that include patient risks. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The trust must ensure that patients do not experience any form of verbal abuse or discrimination from staff, including the use of inappropriate and racist language. Regulation 13 HSCA (RA) Regulation 2014, Safeguarding.
- The trust must ensure patient information is kept confidential. Regulation 13 HSCA (RA) Regulation 2014, Safeguarding.

Action the provider SHOULD take to improve

- The trust should make sure all staff are aware of the ligature risk assessment for the ward they are working on. Also, to record the date of actions being completed of the ligature risk assessment to mitigate risks.
- The trust should maintain accurate records of ligature cutter maintenance.
- The trust should maintain accurate records of access to fresh air.
- The trust should maintain consistent records of long-term segregation on the electronic patient record.
- The trust should consider improving the systems to respond to alarm activation.
- The trust should ensure that debriefs following incidents take place according to the trust policy.
- The trust should ensure they continue to monitor incidences of lone working at night and take steps to eliminate it.
- The trust should enable staff to take breaks, provide access to staff rooms for breaks and monitor the uptake.
- The trust should enable ward staff have adequate physical health care training.
- The trust should communicate clearly the function, referral process and availability of the physical health centre and the team's responsibility.

Nottinghamshire Healthcare NHS Foundation Trust

High secure hospitals

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rampton Hospital	Rampton 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 had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice.
- Staff knew who their Mental Health Act administrators were and reported them to be supportive and helpful.
- Mail monitoring was carried out appropriately in line with Section 134 of the Mental Health Act. This also included information given and displayed about Section 134 mail monitoring. There were good governance processes in place.
- There were good governance systems around the application of mechanical restraint.
- Records reviewed showed occasions when there were not enough qualified nursing staff available to facilitate nursing reviews in line with the Mental Health Act Code of Practice. However, we saw evidence that multidisciplinary team seclusion reviews had improved since our last inspection.
- Patients had easy access to information about independent mental health advocacy. All patients we asked told us they had access to an advocate.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured patients were able to take Section 17 leave (permission for patients to leave hospital) when doctors granted this, and in accordance with Ministry of Justice conditions. All patients had leave for medical treatment.
- Staff requested an opinion from a second opinion appointed doctor when necessary. Patients that did not consent to medication had a treatment certificate approved by a second opinion appointed doctor attached to their medication chart. This enabled staff to know what legal authority they were administering medication by.
- Staff did regular audits to ensure they were applying the Mental Health Act correctly and there was evidence of learning from those audits.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not have a good understanding of the Mental Capacity Act, including the five principles. Staff across the hospital did not consistently understand when patients required a mental capacity assessment for other issues such as managing their finances. Nursing staff did not do this on a decision-specific basis about significant decisions consistently. We raised this as a concern at our last inspection.
- Since our last inspection, the provider had planned to update training for staff around the Mental Capacity Act plans included the establishment of a Mental Capacity Act champion as a resource for clinicians for advice and support by January 2020.
- We saw evidence of staff awareness of supporting people to make advance decisions and we saw examples of crisis plans on the learning disability directorate.
- 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. All patients at the hospital were detained under the Mental Health Act, so deprivation of liberty safeguards did not apply.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.

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

Safety of the ward layout

Ward layouts did not always allow staff to observe all parts of the wards. Staff mitigated risks through observations, the use of closed-circuit television and ensuring patients could not access some areas of wards. Only one staff member reported feeling unsafe due to the layout of the wards, which was an improvement from the last inspection.

Managers developed and updated ligature risk assessments to identify potential ligature anchor points on each ward. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Risk assessments recorded the controls in place to reduce the risk of ligature incidents. However, the ligature risk assessments reviewed on the women's service did not document the date for completion of these actions. We could not see and staff we spoke with were unable to clarify whether these actions had been taken since the ligature risk assessments had been developed in January 2019.

Staff were not aware of where ligature risk assessment records were kept. This issue was raised at the last inspection. Seven of the staff we spoke with individually were not aware of their own ward's ligature risk assessment or where the potential ligature risks were on the ward. On the women's wards, three staff members we spoke with did not know what a ligature risk assessment was. However, staff had developed posters to display in the ward offices to highlight ligature risk assessments.

Not all staff were aware of records of how and when equipment was maintained to make sure it was safe and effective to use. Three staff we spoke with on the women's directorate said there was no record of the maintenance of ligature cutters. Staff checked ligature cutters three times a day but did not maintain a record of when or how these were replaced after use. Staff told us they contacted the security team when they noticed the ligature cutters had been used several times. The trust told us that this equipment was robustly monitored through the health and safety team.

Although the trust had taken steps to address the issue with staff personal alarms, staff continued to report ongoing issues with their personal alarms when summoning help as required. The trust provided assurance that the delay was minimal (approximately one second), but staff remained concerned that this delay presented a risk that other staff would not be aware of incidents occurring within the hospital, causing delays in response times. The trust planned to implement actions to address this issue and to ensure that the alarms were linked with the closed-circuit television system throughout the hospital to improve the accuracy and efficiency of the response. However, this planned improvement had not been communicated effectively to staff.

Response rates to alarms when incidents occurred depended upon staff availability to respond promptly. This had not changed since our previous inspection. Three staff we spoke with on the women's wards reported times where there was a low staff response to a staff alarm call due to staffing pressures. Staff in the focus groups also stated response times depended on staffing levels on the ward. This presents a risk to patients because if staff from other wards do not respond to support an incident. However, during the inspection we saw adequate numbers of staff responding to alarm calls in a timely manner.

Debriefs following incidents did not consistently take place. Staff gave examples of not being able to attend for debrief due to staffing pressures, or debriefs not occurring off the ward. According to National Institute for Health and Care Excellence guidelines on Violence and Aggression: short-term management in mental health, health and community settings, reflecting on what has happened and learning from incidents means that staff can identify and address any physical harm to patients or staff and the emotional impact on patients and staff. If debriefs or reflection do not take place staff may be unable to support patients or other staff appropriately in future incidents.

Security

Managers did not ensure that relational security had been considered when redeploying staff across the hospital. Frequent staff redeployment and staff shortages posed a potential risk of disrupting therapeutic relationships between patients and staff. In addition, it increased the risk

that staff were not familiar with the patient risks and the ward environment. Relational security is the knowledge and understanding staff have of patients and the environment, and the translation of that information into appropriate responses and care.

Staff deployment to other wards posed risks to relational security and staff knowledge of individual risk. During the inspection, staff and patients raised concerns about the impact of staff movement between wards on the therapeutic relationship between patients and staff. Seven of the eight patients we spoke with on the women's wards reported that staff were frequently moved and that this impacted on their ability to build trusting relationships with staff. Three staff we spoke with individually described Topaz and Adwick ward as "pool wards". Staff reported that although staff were allocated to these wards for a shift, they were expected to move to another ward for the duration of their shift to support the demands of the hospital. This impacted on their relationships with patients on these wards.

During our focus groups with nursing staff, staff told us of times when they had been asked to move to a ward where they did not know the patient group, including the risk behaviours and care and treatment needs. Data submitted by the trust demonstrates that 42% of the staff moves from the men's mental health directorate were to another care directorate.

Staff told us they did not have time to support staff who were not familiar with the ward. One patient told us that this unfamiliarity with the patients' needs had led to them misunderstanding a patients' health and dietary needs. Another patient told us that staff from other wards worked differently with her around her risk behaviours because they were not familiar with her care plan. This inconsistency in the patient experience of care presents a barrier to therapeutic engagement between patients and staff. Knowledge of patients and monitoring how they interact is a vital part of maintaining safe care on wards. Serious incident investigations in forensic mental health services have been linked to relational security breakdown as described in See Think Act (Department of Health Guidance on relational security).

Patients and staff did not always feel safe on the wards and cited staffing shortages as the key reason for this. Of the patients we spoke with individually, 18% explicitly stated they did not feel safe on the ward due to a continued shortage of staff. Of the staff we spoke with individually, 13% explicitly stated they did not feel safe on the ward due to a continued shortage of staff.

Staff required all visitors to adhere to strict security procedures before entering the hospital. This included providing proof of identity and participating in personal searches.

Maintenance, cleanliness and infection control

All wards were safe, clean and fit for purpose. All wards were well equipped, well-furnished and well maintained. We observed that furniture was heavy and bolted to the floor to avoid patients using items of furniture as a weapon. This had improved since our previous inspection.

Staff followed the infection control policy including hand hygiene. Hand gel dispensers were full in all clinical areas we visited. This had improved since our last inspection.

We saw information about infection prevention and control displayed around the hospital on noticeboards to remind staff of the key principles. Staff participated in and acted on the findings of infection prevention and control audits.

Seclusion room

Not all seclusion rooms allowed two-way communication. On Bonnard ward, the seclusion room did not have an intercom system which made it difficult for patients and staff to communicate when a patient was using the seclusion room. Staff reported they could communicate effectively when the hatch was open, but this was not always safe. Staff told us there were no imminent plans to address this issue.

Seclusion rooms allowed for clear observation. Managers had addressed a blind spot in the seclusion room on Bonnard ward that we noted during our previous inspection.

All seclusion rooms had toilet facilities and a clock. This had improved since our last inspection.

Clinic room and equipment

The hospital did not always maintain clinic room temperatures at the right level or maintain accurate records of monitoring the temperature in clinic. We found examples of this on five wards across the hospital. On Bonnard ward between 27 and 30 August 2019 the temperature had

exceeded 25 degrees on four consecutive days. This temperature was too high. On Brecon ward the clinic room temperature exceeded 25 degrees on every day in September 2019, but staff had failed to record what action had been taken in response to this. On Coral ward room temperature monitoring was not completed on 12 occasions between July and November 2019, this was highlighted seven times by pharmacy. The maximum room temperature exceeded 25 degrees on 80 occasions. The highest recorded maximum temperature was 32.9 degrees.

Staff did not keep accurate records of clinic room temperature monitoring on Adwick ward and Cheltenham ward.

Staff maintained emergency medicine and equipment. The emergency bag contained cardiac emergency medicines and equipment. The emergency bag was checked by physical health centre staff. A list of their expiry dates and contents was available on the wall of the clinic room.

Supplementary medicines were stored securely in a cupboard in Cambridge ward clinic room. This had been moved since our previous inspection to a more central location for all wards to access. It contained out of hours medicine provision and also those accessible emergency medicines as recommended by the resus council guidelines. Discussion with pharmacy staff indicated that the information regarding the additional emergency medicines held in the supplementary cupboard was communicated to ward staff at the introduction of the system 18 months previously. However, no further communication had been provided from pharmacy.

Overall, staff maintained equipment well and kept it clean. We checked medical devices located in ward areas and found them all to be serviced and in working order. Equipment that had been cleaned and displayed a sticker to indicate the date and time of cleaning. However, we found some blood bottles in the clinic rooms on wards that were out of date. On Cambridge ward 60 of the blood collection tubes for tests in the clinic cupboards were seen to have expired. On Cheltenham ward 18 of the blood collection tubes for tests in the clinic cupboards were seen to have expired. These items were old stock and needed to be removed to reduce the risk of staff using expired equipment and compromising patient safety.

The physical health team always used equipment, including blood bottles, from their own stock, kept at the physical health centre. This reduced risk of old stock being used.

On Cambridge ward we saw a hoist that had been condemned, being stored with other medical equipment. This posed a risk of being used by mistake.

Safe staffing

At our last inspection in July 2019, we concluded that service did not have enough nursing, medical and multidisciplinary staff. We issued the hospital with regulatory notices about staffing at this inspection, as well as at our inspections in 2017 and 2018. We also raised concerns about staffing following two inspections in 2016. Staff raised short staffing as a key theme during our focus groups in June 2019. Although there had been some improvement to staffing pressures, during this inspection, staff continued to raise concerns around staffing.

The central resource office managed requests for staffing for the hospital using staffing data from multiple sources with a reliance on manual analysis of needs and deployment. However, the central resource office could not maintain an accurate oversight of staff movement between wards and therefore could not measure the impact on patient care and treatment. During our inspection, staff did not accurately or consistently capture the movement of staff between wards, including by reporting to the central resource office. Staff reported that they would not notify the central resource office if staff were moved for short periods. The trust clarified that where a member of was required to leave the ward for a brief period (less than half an hour), staff were not expected to record this movement on the electronic system. However, staff from the central resource office confirmed that this meant that staff did not accurately capture staffing requirements, including the movement of staff and that the systems for maintaining oversight and identifying potential hotspots were not always receiving accurate data. This also impacts on the ability for senior leadership to mitigate risks and plan support.

Staff used an electronic rostering system where staff identified when extra shifts were needed. This was not completely embedded and did not accurately reflect staff numbers on the wards and their movement. Staff also completed paper records which were used to provide reports on staffing as these were drawn from the electronic

record. The two different systems did not correlate with each other. We saw an example on 10 September on Topaz ward where there was an overlap of two trips requiring four escorts (one planned and one unplanned) out of the hospital. It took considerable effort to identify from electronic and paper records that there was half an hour where eight staff were off the ward. Similarly, on 13 November 2019 on Emerald ward we saw that the electronic roster showed there were two staff planned to be on the night shift, whereas the paper record showed there were three staff.

Nursing staff

There were 1277 substantive whole-time equivalent staff in post at Rampton hospital as of October 2019. Of these, 365 were registered nurses and 625 were healthcare assistants. The health care assistant posts were over establishment by 13%, to support qualified nursing vacancies.

The vacancy rate for registered nurses was high at 15%. However, this was 1% lower than our previous inspection. The provider had recruited four additional registered nurses and 19 healthcare assistants since our previous inspection in June 2019. Managers were continuing to recruit to vacant posts.

The highest qualified nurse vacancy rates were in the following care streams: women's services (25%), learning disability services (20%), personality disorder services (17%). Women's services and personality disorder services vacancies had both lowered since our previous inspection. However, the learning disability services vacancy rate had increased by 1% since our previous inspection.

At the time of our inspection, the sickness rate was higher than the national NHS average (4.1% in April 2019). The average sickness rate over the past year was 7.1%. This was the same as our previous inspection. The sickness rate amongst registered nursing staff was 6.3%. The highest nursing sickness rates were found in the learning disability services (9.2%) and personality disorder services (8%). These were both greater than the hospital average. This was the same as our previous inspection.

The sickness rate among healthcare assistants was higher overall at 9.1%. The highest healthcare assistant sickness rates were found again in the learning disability services (12.9%) but also within the therapy and education department services (11.1%). These were both greater than the hospital average. Managers performed return to work interviews with staff following periods of sickness.

Within the hospital, there was an average qualified nurse staffing gap of 21% from 1 November 2018 to 31 October 2019, due to vacancies and sickness. The trust mitigated its staffing gap by using low levels of bank staff (3% of available qualified nurse hours and 6% of available nursing assistant hours over the past year) and by deploying staff between wards to meet the shortfall. The hospital had a policy not to use agency staff.

Between June and October 2019, less than 90% of the planned unregistered nurse hours were filled within the therapy and education department, deaf and mental health services.

Rotas showed that actual ward staffing numbers did not always match planned numbers. Wards always had at least one qualified nurse on duty. Ward managers could adjust staffing levels daily to take account of case mix.

The hospital ratio of registered nurses to healthcare workers was low resulting in a dilute skill mix, less experienced teams and gender imbalance on wards. Consultants reported concerns about the skill mix on wards and the impact on managing relational security.

On average, across the hospital, there was a ratio of 1.6 health care assistants to 1 registered nurse. The ratio is lowest in the deaf service (1.1:1) and highest in the LD and women's service (1.8:1).

On average, across the Rampton service is a ratio of 0.7 female staff to every male staff member. The ratio is lowest in the deaf service (0.3:1) and highest in the women's service (4.8:1).

Lone working at night continued to occur. During multiple previous inspections, we have raised concerns about lone working practices. Whilst the trust had taken actions to reduce the episodes of lone working, these had not been effective. Since our previous inspection, lone working at night had increased. During August and September 2019, there were 33 episodes of lone working at night. Lone working puts both patients and staff at risk and prevents the hospital from maintaining safe staffing levels to deal with emergencies.

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Impact of staffing pressures on patient care and treatment

During the inspection, we saw many examples of how staffing pressures impacted on patient care and treatment. Frequent movement of staff between wards inhibits the development of therapeutic relationships and presents both a risk to patient well-being and staff safety. In addition, staff required patients to be confined to side rooms so staff could support their colleagues due to insufficient staffing levels. Although the trust had continued to work to reduce early or late confinement of patients to their side rooms, data submitted by the trust indicated that there had been seven incidents of this happening since our last inspection to 31 October 2019. A patient on Coral ward reported that they had been unable to access their side room as staff were required to maintain safe staffing levels in the wards communal areas. On Bonnard ward, on 7 September and 9 November 2019 patients were asked to use their side rooms due to insufficient staff to support observations in the communal areas of the ward. On 9 November 2019, we saw there were only two staff on the ward to support 14 patients, one of whom required constant observation whilst in seclusion.

We were concerned about reports from patients and staff that they did not feel safe on the wards. Of the patients we spoke with individually, 18% of patients and 13% of staff explicitly stated they did not feel safe on the ward due to a continued shortage of staff. Patients also reported this at our previous inspection.

Patients and staff told us the staffing shortages could be distressing for patients. Staff on Ruby ward described an incident where two patients had engaged in self-harming behaviours whilst several staff supported another patient. The staff member reported patients frequently became agitated when there was limited staff presence on the ward. Three patients told us that the staffing pressures impacted on their ability to access visits from their family members, or that these visits were cut short.

Impact of staffing pressures on patient activities

The number of incidents of staff cancelling patient activities had improved since our last inspection although this still remains a concern. Although some staff reported that there had been a reduction in the number of cancelled activities since our last inspection, 27% of the patients and 24% of the staff we spoke to individually reported ongoing concerns about activities being cancelled due to staffing pressures.

Between August and October 2019, 75 of the planned therapies and education department sessions were cancelled. Of these cancellations, 59 of these were due to staff shortages, staff sickness or occasions where staff were moved to other wards.

The trust had taken steps to improve patients' access to activities, including doubling the number of therapeutic involvement workers and piloting the role of activity coordinators on seven wards with plans to roll this out across the hospital. The women's service had implemented the meaningful day timetable since our last inspection and this encouraged patients to engage in activities as part of the ward structure, including walking groups and craft groups.

Patients we spoke with gave mixed feedback about their access to activities and whether this had improved since our last inspection. Most patients we spoke with on the learning disability wards told us they had good access to activities, but on all other directorates, patient feedback was mixed.

There were ongoing issues with the recording of activities across the hospital. We saw examples on all directorates where staff had not accurately recorded patient activity. For example, on Brecon ward, we saw that on 13 November 2019, staff had not recorded activities for any patients between 11.30 and 8pm. Similarly, on Bonnard ward, staff were unable to find any record of any patient activity on 12 November 2019.

Staff showed us examples of how the system for recording activities did not accurately capture what the activities patients engaged in. On the men's mental health wards, we saw two examples of records that recorded only whether the patient was on or off the ward. Staff told us they did not record what activity the patient was engaged in. This meant we could not accurately determine how much meaningful activity staff offered to patients.

We saw that staff continued to record activities in different places, including on the electronic recording system and on paper records, and that these different recording systems did not match.

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We were not assured that staff ensured patients had access to fresh air. Data submitted by the provider indicated that between 3 June and 27 October 2019, across all services within the hospital, patients took 18% of fresh air hours offered to them by staff. This was significantly lower than our previous inspection when 61% of planned hours had been met. Staff cancelled 29 fresh air session from June to October 2019. We found significant issues with the accuracy of the recording of patients' access to fresh air. During warmer months the door to the garden was left open within the women's service and patients' access to the garden was not always accurately recorded as fresh air. In addition, group walks or walks to other planned activities were not classed as fresh air.

Since our last inspection, staff had shared best practice across directorates around how to improve patients' access to fresh air. For example, the men's mental health wards had reviewed which staff could support patients to access fresh air and included nursing assistants. This had been shared with the learning disability directorate to improve patient access to fresh air.

Impact of staffing pressures on staff

Staffing pressures continued to have a negative impact on some staff's morale. Staff we spoke with individually on Ruby, Coral and Emerald wards reported staffing pressures had continued to worsen since our previous inspection and told us they felt worn down and that they were letting the patients down. However, during our focus group with qualified nursing staff and four staff we spoke with individually reported that morale had begun to improve since our last inspection. Staff reported this was due to cultural changes within the hospital and ongoing recruitment strategies.

Staff worked overtime to try and maintain safe staffing levels. Staff required manager approval to work more than 65 hours overtime in a month.

Managers did not ensure that staff were taking regular breaks and had adequate areas to take a break. Although some staff noted there had been some improvement, eight staff told us that staff shortages impacted on taking breaks and not having time to have bathroom breaks.

Although there were designated areas for staff to take breaks across the hospital, staff in the women's service told us that they struggled to find time to access the area designated for breaks due to its location off the ward. We acknowledged that the trust had a working group to improve access for staff to have breaks, but during this inspection it was too soon to evaluate the impact of the initiative.

The central resource office deployed staff across the hospital to maintain safe staffing levels on wards. Staff referred to this practice as 'loans'. Data submitted by the hospital demonstrates that 46% of the staff loans were from outside of the same care stream. This does not provide us with assurance that the needs of the patient group, including the therapeutic relationship between patients and staff, was duly considered when moving staff around the hospital.

Staffing pressures impacted on the quality of patient notes. For example, on 13 November 2019 staffing pressures resulted in staff not preparing patients' ward round documentation. Staff within the women's and men's service told us that patients records were out of date as they had not be given allocated time to dedicate to these tasks. Staff on Adwick ward had not completed a patient's activity record accurately due to staffing pressures. We were not assured that staff maintained accurate records of patient care and treatment.

Therapies and education staff

Social worker, psychology and occupational therapy caseloads at Rampton are higher than those at the two other high secure services, where comparable data is available.

Social workers had caseloads of 25 patients to each staff member. We raised this as a concern at our last inspection. The current establishment of senior social workers at Rampton hospital was 12.88. The hospital had plans to decommission 18 beds in 2019/20, reducing bed capacity to 304. This meant that social work caseloads would be reduced to 23.6 patients to each staff member. The trust had also commissioned a review of social work input to be undertaken by an external consultant.

At our last inspection, occupational therapists, psychologists and social workers told us their workload hindered their capacity to do their roles fully. At this inspection, these staff groups continued to report ongoing issues with high caseloads. However, these staff groups were aware of plans to reduce their caseloads and improve their experience at work.

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Medical staff

Consultant psychiatrist caseloads had started to reduce from 25 since our last inspection. The number of patients per consultant for women's services averaged 13. The number of patients per consultant for the learning disability service averaged 17. The number of patients per consultant for mental health, personality disorder and the deaf service averaged 20.

The hospital employed some locum consultants to support the reduction in caseload whilst the hospital recruited permanent consultants. As of 1 November 2019, there were 4.8 whole time equivalent locum consultants in post at the hospital. We were told one substantive consultant would be starting in the learning disability service in January 2020.

The medical staff vacancy rate at Rampton was 20% over the past year.

Medical staff provided cover day and night and a doctor could attend wards quickly in an emergency.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments on admission and updated these regularly. Staff used a recognised risk assessment tool called the Historical and Clinical Risk Management which is a comprehensive set of professional guidelines for the assessment and management of violence risk. We looked at 30 care and treatment records across the hospital. All but one of the records we looked at contained an up to date risk assessment. We raised concerns about the one record with missing information with the clinical team during our inspection. This patient had been receiving care and treatment at the hospital for over six months and therefore should have had an up to date risk assessment for staff to use to support this patient safely and effective. We reviewed an incident on one of the mental health wards where a patient had self-ligatured. The risk assessment had not been updated since the incident a week before our inspection. The risk assessment was also overdue its update based on the review date on the record by three days. We also found this in another record at our previous inspection. The service had begun to introduce the Dynamic Appraisal of Situational Aggression (DASA). The purpose of these instruments was to assist health care professionals to identify patients with an increased risk of violence, in order to enable focused preventative interventions.

Management of patient risk

We saw that staff displayed specialist health information in the kitchen on Alford ward around dysphagia and guidance for staff to support patients.

Staff did not always complete observations at irregular intervals, in line with the trust's policy. There was inconsistent implementation of the trust observation and engagement policy by staff on wards that used the paper records to document patient observations. On Quantock ward, we saw that staff had recorded all patient observations at the same time and these observations were signed as having been completed by the same staff member. For example, on Quantock ward, there were times when these observations were recorded for all patients at the same time and at exact, predictable intervals.

However, the introduction of the electronic recording of observations across the 21 of 25 wards, had improved the practice and recording of observations. This was being rolled out across the hospital. Staff reported improvements in the ease of recording observations since the introduction of electronic devices but reported their frustrations that these devices were not linked with other electronic records of patients, stored on the computers. Staff told us this meant they spent time recording the same information several times on different systems. Three staff told us this was a risk to staff spending too long looking at the devices instead of engaging with and observing patients within the ward environment. On Topaz ward, we observed a staff member who had not yet completed their competency check for observations who had recently started working at the hospital recording patient observations whilst logged in to the electronic recording device as another staff member. Recording observations under another staff member's account meant that the record of observations was not accurate.

Staff did not get regular breaks from observations. Staff raised concerns about the impact of completing continuous observations for several hours at a time on both the effectiveness of their observations and their own wellbeing. We saw examples of this on Coral and Ruby ward and on Aintree ward we saw a staff member had been

allocated to completing observations of a patient in seclusion from 07:30 to 11:05 without a break. The trust's observation policy did not state the maximum time staff should undertake continuous observations without a break, although the Rampton hospital observation procedure states, "Any period of observation should not be for more than one hour unless deemed appropriate and therapeutic". During our inspection, we saw that when observations were required for longer than two hours, the hospital did not always ensure staff had regular breaks. This was not in line with National Institute for Health and Care Excellence guidance. We also found this at our previous inspection.

Staff searched patients every time they re-entered the ward. Staff also completed searches of the ward and patient bedrooms in line with hospital policy.

Use of restrictive interventions

The trust had a seclusion and long-term segregation policy which was due for review in January 2020.

The Mental Health Act Code of Practice (2015) defines long-term segregation as 'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis'.

The three national high secure hospitals provided oversight and scrutiny over each other's use of long-term segregation and completed quarterly reviews. The most recent review concluded that Rampton hospital was managing long-term segregation appropriately. However, sometimes there was a lack of staff to give patients who were in long-term segregation access to activities through the door to the room in which they were segregated from other patients. During our inspection, we reviewed a patient's notes on Cheviot ward and found seven cancellations of this nature in the last six months.

During our inspection, we saw evidence that staff worked to reduce restrictive practice. We saw evidence of a reduction in long-term segregation, for example on Adwick and Topaz wards. We saw that a staff member on Adwick was allocated 15 hours per month to focus specifically on ways to reduce restrictive practice, including looking at dynamic risk assessments and barriers to change. There were plans to roll this initiative out to other wards within the hospital. Other examples included on Topaz ward where we saw that no patients were subject to enhanced observations at night. Staff reviewed this daily based on patient risk. We heard of similar examples on other wards where staff had reduced restrictive practices by listening to patients, educating staff about how to support patients effectively and by introducing routine on the ward to promote engagement in meaningful activity.

We observed a ward round for a patient on Emerald ward and saw that staff demonstrated risk-focused, person-centred individualised care planning to support a patient to reduce restrictive practices around the use of strong wear.

Staff did not always follow National Institute for Health and Care Excellence guidance in reviewing the effects of medication when using intramuscular injection medication for managing violence and aggression. We looked at records for patients administered rapid tranquilisation on Coral ward and found that staff did not consistently use a dedicated monitoring form and the record was inaccurate. For one patient, we saw that intramuscular injection medication had been administered on 22 October at 4.55pm, however the patient's physical health observations were not recorded in accordance with the trust policy. Staff were not clear on what the codes for the rapid tranquilisation monitoring form meant. For example, in one patient record it said the patient was alert (coded A) but in the observation record staff had documented that the patient was asleep.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Most patients reported staff used restraint with respect and dignity. Staff made patients aware of the reason for the restraint and provided them with a debrief after the event. Most patients were positive about how staff managed the use of restrictive interventions. However, three patients on Cheviot ward raised concerns about a member of staff who they reported used inappropriate restraint. They also felt that seclusion was used inappropriately and not because of risks to themselves or others. Patients on Blake ward raised similar concerns.

Inadequate

Are services safe?

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We reviewed information about the type and frequency of use of mechanical restraint 1 June to 31 October 2019. In this period there were 242 episodes of mechanical restraint. Seventeen male patients and 15 female patients were subject to mechanical restraint in this period.

The hospital had a policy that detailed how and when to use mechanical restraint. We looked at seven records of patients using mechanical restraint. These demonstrated a clear rationale of use, with an individualised care plan. We saw that skilled staff were allocated to each ward to ensure that less restrictive options were considered and discounted before mechanical restraint was used.

Safeguarding

The trust employed specialist safeguarding leads, including one full time post dedicated to the forensic division. The operational work was led by the social care service at Rampton hospital. The primary resource for safeguarding was the dedicated safeguarding team.

Staff knew how to make a safeguarding alert and provided examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff access to essential information

Staff used an electronic patient record system to record information. Staff used a different electronic record system for primary health care information to the system they used for the patients' main records.

We observed staff using the electronic patient record system and found that staff were not always confident in navigating to all areas of patients' records of care and treatment. Staff told us that there were several different systems for recording information and that this was time consuming and sometimes confusing. Staff across the hospital used the electronic recording systems differently causing some confusion when staff were redeployed to different areas of the hospital.

There was not a consistent approach to flagging medical alerts. We saw that medical alert cards had been stopped in February 2019. Staff were not confident in describing how alerts were now communicated and staff did not routinely add information on medicine charts to the dashboard. We were not assured that there was a consistent approach to flagging alerts and this presented a risk that information was not consistently shared appropriately.

Access to one of the electronic systems, for primary health care information, was limited to the physical health centre staff, ward managers and medical staff. Not all ward staff could access physical health information directly.

There was no formal training for medics to be able to confidently access all electronic recording systems such as the system for primary healthcare information. This meant that there was a risk that not all staff who needed access to electronic records would be able to navigate the electronic system and obtain essential information about patients.

Medicines management

Random checks of the clinic rooms on Cambridge ward and Cheltenham ward stock showed that all medicine stock was within its expiry dates and all insulin pens had appropriate opening dates or new expiry dates.

Pharmacy technicians kept low stock levels and quick rotation of stock to reduce impact of the room temperatures. Pharmacy technicians completed an incident form to highlight when short dated stock was outside of its expiry date. However, medicine stock rotation did not include the medicines stored in the supplementary cupboard. This could impact on the quality of the medicines held in the cupboard for any length of time during a prolonged increase in room temperature.

Staff followed systems and processes when safely prescribing medicines. However, we found that the record of the medicines administered to patients was not always correct. The medicines were also not always stored at the correct temperature and actions were not taken regarding establishing the continued viability of the medicines. This meant patients were at risk of being administered medicines incorrectly because of poor record keeping and that some medicines may be ineffective because of incorrect storage conditions.

There was inconsistency in monitoring fridge temperatures which should be maintained between 2-8 degrees. On Cheltenham ward, staff had not recorded the fridge temperature on eight occasions between July and October 2019, six of which had been highlighted by pharmacy. The last two days where temperature was not recorded were

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followed by two days where maximum temperature was 9 degrees. The minimum temperature was minus two degrees for two days. This was followed by one degree and then zero degree. The only action recorded by staff was to re-set the fridge and the missing records had not been highlighted by pharmacy.

On Coral ward, staff had not completed the fridge temperature monitoring form on two occasions between July and October 2019, on 12 July and 26 September 2019. One temperature of 8.4 degrees was above the maximum temperature of eight degrees. Staff had recorded the action taken as resetting of the fridge.

On Coral ward three patients were administered intramuscular injections to manage the patients' behaviour, according to their prescription chart record. However, discussion with the nurse in charge indicated that one patient did not usually require an intramuscular injection. We noted a lack of information regarding an incident that required staff to administer intramuscular injection to manage the patient's behaviour recorded in the patient's electronic record and a complete lack of monitoring evidence. This indicated that this patient had possibly been administered the medicine orally and not as indicated on record intramuscular.

Staff did not always sign for the administration of medicine. We looked at 37 prescription charts. We found three missing administration signatures in the records we reviewed on Brecon ward but these had all been identified within the pharmacy audit. This had improved since our previous inspection.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Medicines and equipment were stored appropriately at the physical health centre. We found cleaning and maintenance schedules to be in place and up to date. Stock control was good and temperature checks completed appropriately on fridges containing medicines.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Track record on safety

We did not look specifically at incidents during this inspection. Instead, we reviewed how the learning from previous incidents had been shared and embedded since our last inspection. We saw evidence that staff had learned lessons following incidents since our last inspection and that this had been communicated effectively with relevant staff.

Reporting incidents and learning from when things go wrong

Not all staff knew what incidents to report and had time to report them. Six of the staff we spoke with individually and some staff during our focus groups said they did not have time to report incidents due to short staffing. We also found this at our previous inspection. Staff on the men's mental health and personality disorder directorate and women's wards continued to report since our last inspection that they did not always complete incident reports when the ward went below the required safe staffing levels.

The provider had taken action to address the inconsistencies in incident reporting since our last inspection. The trust had begun to establish a campaign using digital information screens and posters to emphasise the importance of staff raising concerns and reporting incidents in enhancing staff and patient safety. They had also reviewed the incident reporting system to make it easier for staff to raise alerts, particularly in relation to safe staffing. However, not all staff were clear on when to complete an incident form. Some staff reported it was if the ward had been short staffed for over a seven hour period others would report after two hours or more. This demonstrated a lack of consistency in the trust sharing the correct procedure to staff. Due to this we questioned the accuracy of the staffing level incident forms.

Staff reported patients were offered a debrief following serious incidents and we saw staff used a proforma for completing these. However, two out of three patients we spoke with on Cheviot ward told us they had not had a debrief after being in seclusion.

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 30 sets of care and treatment records across the hospital. Most records included comprehensive care plans that demonstrated patient involvement, were written in the patient voice and were updated regularly, including after an incident. One record we reviewed on Bonnard ward had some sections that had not been updated in line with the required frequency.

Overall, patients' care plans reflected their individual needs and treatment goals and these care plans were cross-referenced to the patient's risk assessment. Staff developed care plans that were detailed, holistic, person-centred and matched the needs of patients. We saw examples of excellent person-centred, individualised care plans. For example, on Aintree ward, staff had reviewed camera footage of a patient's communication with staff to develop a specific communication care plan to support staff to tailor their care to this patient's individual communication needs. However, on other wards we noted examples where care plans varied in their level of detail and specificity to the individual patient's needs.

Staff completed positive behaviour support plan for patients on the wards for people with a learning disability. Staff used these care plans to good effect to support effective communication with patients. Where required, patient care records were available in easy read format for patients.

Most of the records we reviewed demonstrated that staff had offered patients a copy of their care plan and staff had clearly documented when a patient had refused this offer.

Patients with physical health needs had care plans developed by the physical health care team. We saw collaborative working with staff on wards to develop the plans. There was a National Early Warning Score and sepsis flow chart in place to aid ward staff in following the monitoring and escalation process. Patients with physical health needs that we spoke with said that they received appropriate support.

Staff did not always identify or respond to changing risks to or posed by patients. We saw an example of this on one of the wards where a patient had been involved in an incident involving serious self-harm, but staff had not updated the patient's care plan to reflect this change in risk behaviour.

The physical health centre completed physical health checks and wrote physical health care plans. We saw these plans were detailed, person-centred and included both long- and short-term goals.

A team of new staff was in place to manage the physical health centre located at the centre of the hospital. The staff were enthusiastic and passionate about supporting patients. We saw plans to introduce health care clinics to support the management of physical health across the hospital. These included a well-man clinic, ear care clinic and awareness clinics for cancer. However, we found that registered mental health nurses relied on the registered general nurses to provide physical health care and there appeared to be a lack of confidence by the ward staff when dealing with patient's physical health needs.

The physical health care team were keen to promote physical health awareness and had liaised with the learning and development team to create a programme for staff to improve awareness of physical health. Although a plan had been developed and was in progress, training for staff around physical health care was minimal and this remained a risk. Some staff said that confidence in managing patient physical healthcare was low and more support would be beneficial.

There was improved recording of The National Early Warning Score system, which aims to standardise the assessment and response to acute illness. We looked at 46 sets of patients' National Early Warning Score charts across the hospital. We saw that in all but three (7%) of these charts, staff had maintained accurate records of patients' physical health.

Staff completed regular audits of National Early Warning Score records. However, we reviewed an audit on the wards for men with a personality disorder and found that actions that had been highlighted in a previous audit had not been reviewed or completed since 2018.

Although most doctors had access to the electronic record system for primary healthcare information, not all were trained or confident in using the system. This presented a risk at weekends and for those on call.

We saw plans to introduce processes to improve physical health management for patients. These included the Situation, Background, Assessment, Recommendation communication model for handovers, physical health

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specific training and training for electronic patient records. There were also plans to introduce refreshed physical healthcare training for all nurses to establish telemedicine and enhanced services such as ultrasound on site.

Best practice in treatment and care

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. The majority of patients reported good access to good physical healthcare facilities, including access to specialists when needed. However, three patients told us there were delays in accessing support for their physical healthcare.

The physical healthcare centre operated seven days a week. This had only recently been implemented two weeks prior to our inspection and staff we spoke with said they found this beneficial. The physical healthcare centre offered a range of services. Specialist staff such as a consultant neurologist ran surgeries at the physical health centre. This included GPs, tissue viability nurses, podiatrists, physiotherapists, opticians, and dentists. Palliative care nurses were available to provide support.

The National Early Warning Score system was in use and staff could describe the process that was in place to manage patients with deteriorating physical health. However, the process was still in its infancy and was not embedded into the culture. The National Early Warning Score system aims to standardise the assessment and response to acute illness. We examined the National Early Warning Score charts of 46 patients and found them all but one to be completed using every trigger to formulate a score. We followed the escalation process for five and found that they were recorded on patient notes, both electronic and paper. Care was given appropriately to all five patients that we tracked. This had improved since our previous inspection.

We visited the Jasmine suite to speak with a patient that was at the end of their life. The area was appropriate to their needs and considerations had been made to cater for the patient. We saw good examples of reflective practice taking place to support staff in their care and treatment for this patient. The ward manager discussed refurbishment of the area to make it more suitable for future patients in similar circumstances.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration.

Staff used recognised rating scales to assess and record severity and outcomes for example, Health of the Nation Outcome Scales.

Staff told us they did not take part in any national audits linked to physical health.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the wards.

Senior managers told us that staff competence and confidence needed to be built up to make clinical and management decisions based on risk, rather than always focusing on the numbers of staff available. To support this, the trust had appointed two team leaders to work clinically with staff across the hospital. It was too soon to evaluate the impact of this.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank staff.

Managers gave each new member of staff a full induction to the service before they started work.

The quality of clinical supervision staff received remained inconsistent. Data submitted by the trust indicated that for October 2019, overall clinical supervision compliance for staff within the hospital was 69%. This was lowest in the learning disabilities directorate where supervision compliance for staff was 65%. Nine individual staff from different directorates reported issues with access to and the quality of supervision as a result of time pressures. Four members of staff from the men's mental health wards told us they falsely documented they had received supervision when they had not had time. However, staff in focus groups reported receiving regular good quality supervision. The hospital had developed an audit to review the frequency and quality of supervision which it planned to implement.

Staff recorded and filed management supervision in the staff personnel file. Management supervision followed a standard agenda and checked that the employee had received clinical supervision. We reviewed three management supervision files and saw staff had briefly recorded the areas discussed. This included work-life

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.

balance. Staff also reported access to weekly group supervision on the wards. However, staff within the psychology department reported a lack of time to provide group supervision sessions with ward staff.

Doctors and psychologists said their clinical supervision and support was good.

Not all staff had received an appraisal within the last 12 months. The percentage of staff that had had an appraisal between 1 November 2018 and 31 October 2019 was 71%.

Managers dealt with poor staff performance promptly and effectively. We saw evidence that this happened.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care and multidisciplinary team working took place. However, social workers, occupational therapists and psychologists told us that high caseloads put a strain on this. Sometimes this meant that reports were emailed to the multidisciplinary meetings rather than attendance by all members.

Staff did not always share information about patients through handover meetings. This was the same as our findings from our previous inspection. Staff we spoke with in our focus groups and individual interviews raised concerns about the quality of handovers and reported a lack of time to ensure staff were aware of each patient's current clinical risks.

Four staff we spoke with individually told us the handovers they received when moving to a different ward were not always effective because staff on the ward were so busy. See, Think, Act guidance sets out the importance of relational security and identifies a number of steps which are important in maintaining boundaries: including the use of handovers to let the team know when and how staff have used their judgement on a boundary.

Care programme approach meetings were held regularly and were well managed. We observed a care programme approach meeting on Cheltenham ward and another on Blake ward. These meetings were well attended, positive and person-centred with a clear focus on improving outcomes for the patient.

Most patients reported good access to psychology across the hospital and we saw evidence of psychological input in patient care records. We saw evidence that patients had access to a range of psychological therapies, tailored to their needs. If patients refused to engage with psychology sessions, we saw that the psychologists developed a non-engagement plan to evidence how they were working to engage the patient in therapeutic work. However, three patients we spoke with told us they were frustrated at not having access to therapeutic treatments due to a lack of psychology support available and reported this led to them being stuck in the hospital.

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

Staff did not maintain records of long-term segregation consistently on the patient electronic recording system. One staff member we spoke with could not find long-term segregation reviews as staff stored information in different places on the system. However, we saw evidence that the care planning around long-term segregation had improved, including exit plans for what patients would need to do for long-term segregation to be ended.

Seclusion recording was difficult to follow as it was not recorded chronologically. We found missing records of medical reviews, nursing reviews and multidisciplinary team reviews and occasions where there were not enough qualified nursing staff available to facilitate nursing reviews in line with the Code of Practice. However, we saw evidence that multidisciplinary team seclusion reviews had improved since our last inspection and that these reviews contained a representative sample of the multidisciplinary team.

Mail monitoring was carried out appropriately in line with Section 134 of the Mental Health Act. This also included information given and displayed about Section 134 mail monitoring. There were good governance processes in place.

Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and reported them to be supportive and helpful. For example, staff told us Mental Health Act administrators sent them prompts when patients' Section 132 rights were due for renewal. The provider had relevant policies and procedures that reflected the most recent guidance.

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Patients had easy access to information about independent mental health advocacy. All patients we asked told us they had access to an advocate.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured patients were able to take Section 17 leave (permission for patients to leave hospital) when doctors granted this, and in accordance with Ministry of Justice conditions. All patients had leave for medical treatment.

Staff requested an opinion from a second opinion appointed doctor when necessary. Patients that did not consent to medication had a treatment certificate approved by a second opinion appointed doctor attached to their medication chart. This enabled staff to know what legal authority they were administering medication by.

Staff did regular audits to ensure they were applying the Mental Health Act correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

Staff did not have a good understanding of the Mental Capacity Act, including the five principles. Staff across the hospital did not consistently understand when patients required a mental capacity assessment for other issues such as managing their finances. Nursing staff did not do this on a decision-specific basis about significant decisions consistently. We raised this as a concern at our last inspection.

Since our last inspection, the provider had planned updated and improved training for staff around the Mental Capacity Act and had plans to identify a clinical team Mental Capacity Act champion as a resource for clinicians for advice and support. The trust had plans to introduce this by January 2020 and it was too soon to evaluate the impact of this at our inspection.

However, we saw evidence of staff awareness of supporting people to make advance decisions and we saw examples of crisis plans on the learning disability directorate.

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. All patients at the hospital were detained under the Mental Health Act, so deprivation of liberty safeguards did not apply.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Requires improvement

Are services caring?

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

Our findings

We did not focus on all key lines of enquiry in this domain.

Kindness, dignity, respect and support

At our previous inspection, a minority of patients and staff told us that a few staff had used or condoned the use of racist or other inappropriate language towards patients. On this inspection a minority of patients in the mental health and learning disability care stream told us that racist language and inappropriate language was still being used.

Not all staff showed kindness, dignity, respect, compassion and support when working with patients. We observed during the inspection on Brecon ward staff shouting across the ward at patients. Five out of seven patients on Blake ward reported that staff members had a bullying culture, all five named the same member of staff. A staff member of Aintree ward reported that some staff ridiculed patients and that this was not reported due to fear of retribution. We raised these concerns during our inspection on the patient's behalf. On Bonnard ward, one patient told us a staff member bullied patients and never prioritised patients' needs, reporting he felt uncomfortable and anxious whenever this staff member was on shift. Another patient on this ward told us staff make sarcastic comments towards patients, leaving them feeling uneasy and lacking trust. Two patients reported that staff were racist, but these patients did not want to be identified. The trust had commissioned advocacy to work with patients to understand this more and discussion had taken place at the leadership council meetings.

However, during our inspection, the majority of interactions between staff and patients and staff that we observed were positive and demonstrated compassionate, dignified and person-centred care. For example, we observed staff interacting with patients on Topaz ward, including a discussion in which a patient asked a staff member about their discharge plans in a communal area where other patients were present. We saw how the staff member protected this patient's privacy by lowering their voice and responding professionally to the questions the patient had asked. We saw that staff had a good understanding of individual patients' needs and overall, staff had positive therapeutic relationships with patients. We observed that staff valued the importance of engaging with patients, including when completing observations of patients. The majority of patients reported that staff spoke in a respectful manner and listened. We saw good examples of staff delivering compassionate care on all of the directorates within the hospital.

On some wards in the men's mental health directorate, there were two showers located next to each other, separated by a partition wall. Two patients we spoke with on Alford ward reporting feeling uncomfortable with the lack of privacy when entering or leaving the shower cubicle. This compromised patient privacy.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff did not consistently follow policy to keep patient information confidential. On Brecon ward a patient told us they were frequently aware of other patients' needs and risks due to staff talking openly about patients in communal patient areas. One patient on this ward listed six other patients' healthcare needs and observations to a member of our inspection team.

The involvement of people in the care that they receive

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Not all patients told us that staff involved them in and gave them access to their care planning documents and risk assessments. However, all patients told us they were kept informed about their medication care plans and any expected side effects. We saw evidence that staff worked closely with patients to help them understand their care and treatment needs and found ways to communicate with patients who had communication difficulties.

We saw examples of staff using various methods to communicate with patients, including to reduce restrictive interventions and conflict. For example, on Blake ward, we saw patients using flash cards to communicate with staff their current presentation.

Most patients had access to regular community meetings where staff sought their feedback. However, we looked at records of community meetings on Quantock ward and saw that there was no record of a community meeting

Are services caring?

Requires improvement

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since 25 October 2018. However, we spoke to two patients on this ward who told us they did have regular community meetings. Staff encouraged patients to give their feedback through care opinion.

Involvement of families and carers

Staff supported, informed and involved families or carers.

Staff helped families to give feedback on the service.

We observed a Care Programme Approach meeting on Blake ward where a patient's family attended the meeting. We saw the team involved the patient's family members in discussions about their relative's care and encouraged them to share their feedback on the care and treatment offered by the hospital.

Are services responsive to people's needs?

Requires improvement

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

Our findings

We did not inspect this domain during this focused inspection.

Are services well-led?

Inadequate

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

We did not focus on all key lines of enquiry in this domain.

Steps taken by the trust to address the staffing pressures

We reviewed the trust's quality improvement plan and what actions the provider had taken since our last inspection to address our concerns about staffing. Actions the trust had taken to address staffing pressures included completing ward establishment reviews for all areas, as well as:

- The trust had recruited to over establishment levels of staff by recruiting more unqualified staff. They remained under established for qualified staff. New posts had been agreed, recruited to or were under recruitment for additional therapeutic involvement workers. Staff and patients reported this had resulted in an improvement in access to activities and reduced the reliance on clinical staff to run therapeutic activities on the ward
- The Trust has created new consultant posts and had recruited locums in the interim whilst recruiting to substantive posts.
- The psychology department had been given the agreement to recruit to five assistant psychologist posts to reduce the workload of qualified staff and the education and training department had seen an increase in staffing and reported this had improved since our last inspection.
- The provider were awaiting the arrival of 17 out of 40 new nurse associates who were due to join the service in March 2020, equipped with enhanced physical healthcare training.
- The hospital were exploring further support posts for escort staff for the health centre and activity coordinators.
- The hospital had recruited additional staff to work in the healthcare centre and this was now open seven days a week.
- The trust board were considering the proposal to introduce an additional incentive payment for patient-facing staff however this decision had not been made at the time of our inspection.
- The hospital had health and wellbeing champions on all wards who were led by the wellbeing matron. The hospital continued to implement a range of well being initiatives for its staff.
- The hospital had recruited two new team leaders dedicated to supporting new starters and to support competency and confidence-building of staff on the wards. However, they had not yet started at the time of our inspection.
- We were told that Canterbury ward would be merging with Cambridge ward and that the staffing situation would improve after the merger in December 2019.
- Senior managers told us that they spent time on the ward monitoring the staffing action plan but it was too soon to measure the impact. Some staff confirmed that there was no risk identified with the approach that had been taken to increase non-qualified staff numbers to compensate in the shortfall of qualified staff. Following our inspection, the trust confirmed it acknowledged that whilst the increased number of unregistered staff supporting the hospital in terms of the overall number of available staff is of benefit; this does present potential risks in terms of a reduced skill mix which may impact in terms of leadership at the point of care and increased pressure placed upon registered staff who may be required to take on greater responsibilities for longer periods.

Leadership

Since our last inspection, the trust had begun to make changes to its senior management at board level. The trust had appointed a new chair, chief nurse, and four non-executive directors who were waiting to start their appointments. The medical director had been appointed as interim executive director of forensics, whilst the substantial post was advertised. A dedicated associate medical director had been appointed specifically for Rampton hospital. Five medical care leads had been appointed for the care pathways at Rampton hospital. It was too soon to evaluate the impact of these changes.

Consultants at the hospital welcomed the senior clinical leadership provided by the acting executive director of forensics and were hopeful that clinical and managerial relationships would be strengthened. Hospital site managers reported strengthened relationships with clinical leaders such as modern matrons. This was an improvement on the last inspection.

Staff reported feeling positive about the appointment and visibility of the new chief executive officer and said they felt listened to by senior staff.

Are services well-led?

Inadequate

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.

Staff had the opportunity to engage in leadership opportunities. The hospital had introduced a leadership programme for band six staff and 80 staff within the hospital were completing this programme at the time of our inspection. However, some staff reported issues with unfair recruitment to these roles, reporting that longer-standing staff were not given the opportunity to participate in these roles.

Culture

At our last inspection, we raised concerns about the culture within the hospital and told the provider they must take steps to investigate how widespread is the use of racist language and other inappropriate language by staff towards patients and stop this. The hospital had commenced work to understand the experience of patients and staff in relation to racist language being used. Advocacy had been commissioned to work with patients to understand this and it was an agenda item for the patient's council. The Speak up Guardian had increased their presence to enable staff to raise concerns. The trust also had plans to introduce a new Divisional Equality and Diversity Lead role to support shared education and learning by January 2020. Staff reported that some improvements were being seen in the culture, however it was too soon to evaluate the impact of these initiatives.

During this inspection, we raised a concern about the culture on Blake ward. The hospital governance systems had already picked up these concerns and actions were being taken. The hospital reacted responsively to our concerns by raising a safeguarding concern and carried out immediate actions. The hospital were going to apply their ward cultural methodology to support improvement on the ward.

Staff continued to be fearful of speaking up about their concerns. During our last inspection, some staff told us there was a bullying culture within some areas of the hospital. During this inspection, we asked staff whether there had been any ongoing issues or improvements in this area and our concerns remain about the culture of the relationships between staff and management. Three staff from the women's directorate reported feeling reprimanded for reporting incidents and two other staff approached us during the inspection and told us they had been told to "behave" during discussions with our inspection team. In addition, two other staff on the women's directorate reported being fearful of speaking up and another staff member told us they would be told off if they spoke up.

The provider told us they had taken action since our last inspection to encourage an open and honest culture within the hospital, including hosting a freedom to speak up month to promote the role and purpose of the speak up guardian and the development of a new senior nurse post created to lead on inclusion, cultural awareness and the promotion of zero tolerance to racism. The hospital had commenced "Just culture" work using the Mersey care model. This included improved wellbeing offers to staff and some staff we spoke with were aware of the wellbeing team.

The hospital planned to implement Schwartz rounds (an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients in a safe environment and offer support to one another). However, the impact of these initiatives was not yet felt by all staff at the time of our inspection.

All wards had taken part in away days to review their achievements and identify areas for improvement.

Good governance

A Rampton hospital quality improvement plan was in place and shared with us at the time of inspection. It was too soon to evaluate the impact of the action plan. An implementation board had been established to monitor the improvement plan, which was chaired by the chief executive. The implementation board reported directly to the trust board. There was good representation on the implementation board. This included a non-executive lead and consultant medical staff representation.

Staffing the hospital was a complex issue requiring a lot of movement of staff to fill in shortfalls. Our observations and review of data led us to conclude there was a lack of strategic oversight of staff on the wards, especially where staff were moved frequently to accommodate off site visits. We observed a daily demand meeting and saw that whilst staff were allocated to support the numbers required on each ward at any given time, we were not assured that the discussions and decisions made in this meeting considered the patient experience of having familiar staff moved to a

Are services well-led?

Inadequate

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different ward. There were multiple systems used to record staffing data used on a daily basis. We found multiple versions of paper rotas and electronic rotas kept in various places across the hospital that did not correlate.

A multi-agency risk review meeting took place during the week of our inspection. This included the trust representation. Different agencies offered to support the hospital to address some of its challenges. There was good systemic ownership of the challenges faced by the hospital. The risk review meeting acknowledged there were differences in the financial tariff between the three high secure hospitals, in which Rampton hospital received less funding despite delivering national services. There was agreement to working to resolve this issue. At the risk review meeting the specialist commissioners reported on their findings from their visits undertaken and feedback from other regional commissioners. Their findings echoed many of our finding from our previous inspection.

There were governance systems in place to monitor physical healthcare. The trust had a physical health policy and a multidisciplinary physical health steering group. However, we noted issues with the quality and effectiveness of audits around National Early Warning Scores records.

Engagement

During our inspection, the trust had a ceremony to give out awards in relation to their Outstanding Service Contribution and Recognition Scheme (OSCARS). Kempton ward won an award for best team and for the nurse of the year.

Most staff reported improvements in communication from senior managers. Staff reported being more hopeful that changes in leadership will bring about engagement and involvement in decision making. We held two staff forums which were attended by specialty doctors and the physical healthcare centre team. The group said there was some frustration in the pace of change at the hospital. However, it was recognised that the changes were positive and would improve patient physical health care.

Staff from the psychology department continued to report a lack of feedback and engagement from the senior leadership team about their job stability and reported this was extremely stressful. Following our inspection, the trust informed us that these roles that been made substantive.

The hospital gave patients and carers opportunities to give feedback on the service they received. The hospital had also commissioned an independent patient survey to look at inclusion, exclusion, racism and bullying. The hospital had a strategy to improve communication to patients on key messages with clear opportunities for their voice to be heard and acted upon.

Patients and carers were involved in decision-making about changes to the service. For example, the hospital had established patient panels for all clinical post interviews. The hospital also involved patients in improvements to and the co-design of ward environments, following the successful implementation of West Fields development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that safe and consistent processes are used to support patient's physical health care requirements in line with the trust policy. The trust did not ensure that all staff adhere to the trust's observation policy when conducting and recording observations. The trust did not ensure staff follow National Institute for Health and Care Excellence guidance in reviewing the effects of medication when using intramuscular injection medication for managing violence and aggression. The trust did not ensure staff receive effective handovers that include patient risks. This was a breach of Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust did not ensure that patients do not experience any form of verbal abuse or discrimination from staff, including the use of inappropriate and racist language. The trust did not ensure patient information is kept confidential. This was a breach of Regulation 13 HSCA (RA) Regulation 2014, Safeguarding service users from abuse and improper treatment

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 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not ensure staff report all incidents required accurately and in a timely manner. This was a breach of Regulation 17 HSCA (RA) Regulation 2014, Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not ensure there is adequate staffing across the hospital to keep patients safe and meet their needs, including ensuring social workers, psychologists and occupation therapists are able to meet the needs of all patients in their care. This was a breach of Regulation 18 HSCA (RA) Regulations 2014, Staffing