CareQuality Commission

Inadequate 🔴

Nottinghamshire Healthcare NHS Foundation Trust
High secure hospitals
Quality Report

Rampton Hospital
Retford
DN22 0PD
Tel: 0115 9691300
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	Adwick- Mental health	DN22 0PD
RHA04	Rampton Hospital	Alford- Mental health	DN22 0PD
RHA04	Rampton Hospital	Blake- Mental health	DN22 0PD
RHA04	Rampton Hospital	Bonnard- Mental health	DN22 0PD
RHA04	Rampton Hospital	Burne- Mental health	DN22 0PD
RHA04	Rampton Hospital	Canterbury- Mental health	DN22 0PD
RHA04	Rampton Hospital	Cambridge- Mental health	DN22 0PD
RHA04	Rampton Hospital	Erskine- Mental health	DN22 0PD
RHA04	Rampton Hospital	Grampian- Deaf service	DN22 0PD
RHA04	Rampton Hospital	Aintree- Learning disabilities	DN22 0PD
RHA04	Rampton Hospital	Cheltenham- Learning disabilities	DN22 0PD
RHA04	Rampton Hospital	Kempton- Learning disabilities	DN22 0PD

Summary of findings

RHA04	Rampton Hospital	Newmarket- Learning disabilities	DN22 0PD
RHA04	Rampton Hospital	Brecon- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Cheviot- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Cotswold- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Eden- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Hambleton- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Malvern- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Quantock- Personality disorder	DN22 0PD
RHA04	Rampton Hospital	Coral- Women's Services	DN22 0PD
RHA04	Rampton Hospital	Emerald- Women's Services	DN22 0PD
RHA04	Rampton Hospital	Jade- Women's Services	DN22 0PD
RHA04	Rampton Hospital	Ruby- Women's Services	DN22 0PD
RHA04	Rampton Hospital	Topaz- Women's Services	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.

Summary of findings

Ratings

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

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

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

Our rating of this service went down. We rated Rampton Hospital as inadequate because:

- Our ratings of safe and well-led went down to inadequate, our ratings of effective and caring went down to requires improvement, and our rating of responsive stayed the same at requires improvement.
- The hospital had not dealt fully with issues raised at our last inspection and made the subject of requirement notices. Following the inspection we told the provider about our concerns. The provider gave us some assurance about these concerns and we will follow up their action plan through inspections and monitoring activity.
- The service did not provide safe care. There were not enough staff to provide safe and effective care and treatment for patients. This had a direct impact on patient care and treatment through cancellations of patient activity, the use of restrictive practices and low patient and staff morale.
- Medicines were not always managed safely. We issued the trust with a requirement notice on this at our last inspection and it had not been fully dealt with.
- Not all the ward environments were clean. We issued the trust with a requirement notice on this issue at our last inspection and it had not been fully dealt with.
- Although patients had access to the full range of specialists required to meet their needs, this was compromised by high caseloads of some specialists such as psychologists, occupational therapists and speech and language therapists. Some specialists worked as ward staff to support short staffing. Staff did not always report incidents of activities being cancelled or staffing shortages due to time constraints.
- Staff still did not always ensure patients had good access to physical healthcare in a timely manner. They did not always accurately monitor patients' physical health or implement physical healthcare plans. We raised concerns about the implementation of physical healthcare plans at our last inspection and issued the trust with a requirement notice to make improvements.

- Staff still did not always review patients in seclusion in accordance with the Mental Health Act Code of Practice. Following our last inspection, we issued the trust with a requirement notice that they must make improvements in this area.
- Staff across the hospital did not demonstrate a competent understanding of when a patient required a mental capacity assessment for issues other than consent to treatment.
- Some staff and patients raised concerns about staff attitudes and staff using or condoning the use of racist and other inappropriate language towards and around patients.
- The service was not consistently responsive to the needs of the patient group for whom they provided care and treatment. Although the service were trying to ensure there were enough staff trained to level 3 British Sign Language, patients who were deaf reported that staff were limited in their interactions with them and said this impacted on their ability to communicate with staff effectively.
- Staff did not trust or feel listened to by the senior leadership team. Staff morale was low and staff did not feel valued or supported. They did not feel able to raise concerns without fear of retribution.
- There was lack of engagement and involvement in decision making between medical consultants and management. We raised this at our previous inspection and improvements were still required in this area. There were tensions between hospital security managers and clinical leaders.

However:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Staff engaged in clinical audit to evaluate their work.
- Most staff, patients and carers told us that staff treated patients and their carers with dignity and respect. We observed positive interactions between patients and staff. Overall, staff involved patients in their care planning and care plans were personalised and holistic.

Summary of findings

- The hospital was introducing innovative practice using information technology to provide patients with access programmes to complement their therapy treatment and to carry out observations.

Summary of findings

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

Are services safe?

Inadequate ●

Our rating of safe went down. We rated it as inadequate because:

- The trust had miscalculated the number of staff required to provide safe and effective care and treatment to patients. Most days the hospital was short of nursing staff, based on the numbers required to meet the needs of the patient group. The service did not have enough nursing, medical staff, allied professionals and education and training staff to cover the needs of the wards, provide escorts to support patients' out of grounds leave or to supervise and monitor seclusion and long-term segregation properly. To maintain safety, staff were moved between wards, worked additional hours and went without breaks. The impact on patients was a reduction in activities, limited access to fresh air and to one to one time with staff. There was lack of clarity amongst staff about when the hospital should consider staffing to be escalated as a serious incident to senior managers.
- Staff shortages meant the hospital did not have the right balance between maintaining safety and providing the least restrictive environment possible. This resulted in the early confinement of patients to their bedrooms, lone working for night staff and patients being confined in communal areas.
- There were problems with staff responding to alarms. Staff reported that when two staff activated their alarms at the same time they did not work properly, and this resulted in delays in responding. Staff shortages also caused delays in responding to alarms.
- Staff did not always report incidents or did not write them up in detail due to concerns about managers' reactions and time pressures.
- Staff did not consistently adhere to the trust's observation policy when recording observations. Staff did not always receive breaks from continuous observations.
- There was a lack of consistency in signing medication charts to show medicines had been given and some stored medicines were past their expiry date. Staff did not consistently maintain safe and effective clinic room and fridge temperatures.
- There were infection control risks. Not all kitchens and patient fridges were clean. Several hand gel dispensers were empty.
- Not all staff were aware of the ligature risk assessment for the ward they were working on.

However:

Summary of findings

- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, whether paper-based or electronic.

Are services effective?   Requires improvement ●

Our rating of effective went down. We rated effective as requires improvement because:

- Staff did not all see physical healthcare as being part of their role. Staff expected the physical healthcare centre to support patients with minor issues that could have been managed on the wards. Staff did not transfer weight loss plans from the daily record into care plans. In one incident, staff did not give gastronomy feed to a patient due a lack of trained staff being available. National Early Warning Scores were either not completed accurately or acted upon in line with national guidelines consistently.
- Staff reported the quality of clinical supervision was not good. Psychologists reported that they did not always have the capacity to provide group reflective practice/group supervision.
- Team meetings were not held consistently and were often cancelled due to short staffing.
- The quality of care and treatment offered to patients was affected by staff shortages. The over reliance on healthcare assistants, high caseloads amongst multidisciplinary team members and several examples of members of the multidisciplinary team being used on inappropriately on wards to support clinical activity as opposed to their own roles had an impact.
- Staff across the hospital did not demonstrate a competent understanding of when a patient required a mental capacity assessment for issues such as managing their finances.
- The recording of seclusion and long-term segregation demonstrated that reviews were not undertaken in accordance with the Mental Health Act Code of Practice. The hospital did not record a plan for the following six-month review period after long-term segregation reviews. Care programme approach meetings did not always discuss how to support patients to come out of long-term segregation and reintegrate into the ward.

Summary of findings

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the patients' assessed needs, were personalised, holistic and recovery-oriented in four out of the five care streams. 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.
- Managers supported staff with appraisals. Managers provided an induction programme for new staff.
- The ward teams had effective working relationships with other teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.

Are services caring?

Our rating of caring went down. We rated caring as requires improvement because:

- Patients and staff told us that a minority of staff had used or condoned the use of racist and other inappropriate language towards patients. Some staff and patients raised concerns about staff attitudes towards patients and one patient described a coercive atmosphere where staff asserted power over patients.

However:

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

Requires improvement ●

Are services responsive to people's needs?

Our rating of responsive stayed the same. We rated responsive as requires improvement because:

Requires improvement ●

Summary of findings

- There were delays along the patient pathways within the hospital. There were 18 delayed discharges for non-clinical reasons that were mainly outside of the control of the hospital. Whilst the average length of stay was 6.8 years, there were 78 patients who had been in hospital over 10 years.
- Patients in long-term segregation on the women's wards reported difficulties with talking through a small opening in the door. They reported it was difficult to hear staff and have a two-way conversation.
  Therapies and education department cancellations often included horticulture and day centre groups. Staff reported they did not accurately record patient activity and cancellations of activity due to time constraints.
- Short staffing resulted in delays in serving food at meal times which meant the food was sometimes served cold.
- Patients reported there was a shortage of level 3 British Sign Language trained staff resulting in limited interactions. This made patients feel lonely, unsafe, and misunderstood.

However:

- Staff liaised well with services that would provide aftercare.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with the whole team and the wider service.

Are services well-led?   **Inadequate** ●

Our rating of well-led went down. We rated well-led as inadequate because:

- The hospital had an unhealthy staff culture. Staff did not feel respected, supported and valued. Staff morale was low, mainly due to staff shortages. Staff were fearful of speaking out and said they did not always report incidents due to fear of reprisals.
- There was a lack of trust and confidence in the senior forensic leadership team. Some senior managers did not feel listened to. Medical consultant and senior management relations had not significantly improved since our last inspection. Medical consultants did not feel listened to or involved in management decisions. There were tensions between the senior clinical leaders, for example modern matrons and hospital security site managers.

Summary of findings

- Staff did not feel connected with the rest of the trust and did not fully understand the hospital's vision and values and how they were fitted in with the trust. Staff reported a disconnect between the clinical teams and the hospital's senior leadership team.
- Whilst there were good governance systems our findings from the other key questions demonstrated that governance processes did not operate effectively enough to manage the impact of staff shortages on the patient and staff experience. Staff were not clear about how the governance systems supported them to carry out their roles.

However:

- Leaders at ward level were undertaking leadership development to enhance their skills, knowledge and experience to perform their roles. Ward leaders were visible in the service and approachable for patients and staff.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

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 specialist commissioning 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 and are classified as having a learning disability, or mental illness or a psychopathic disorder, or both.

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 were 291 patients in 25 wards with 34 patients on trial leave. The hospital employed 1274 whole time staff. The annual budget was £94 million.

The hospital had 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 including the Peaks unit for people with enduring and severe personality disorders with 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, 12 CQC inspectors, one CQC pharmacist specialist, one CQC medicines team support officer, one CQC assistant inspector, six specialist advisors experienced in forensic services, including four mental health nurses, one psychologist and one advisor with specific knowledge of advocacy, one CQC analyst, one CQC inspection planner and one British Sign Language interpreter.

Why we carried out this inspection

We undertook this inspection of Rampton Hospital in response to concerns raised from a range of sources. We received information of concern from consultant medical staff at the hospital. Our Mental Health Act Monitoring activity and focus group interviews with clinical staff at the hospital also highlighted significant concerns. As a result, we brought forward this inspection to find out more about these concerns and check whether the trust had made the improvements required following our previous inspections of the hospital. We plan our inspections based on everything we know about the service, including whether they appear to be getting better or worse.

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 undertook a comprehensive inspection of Nottinghamshire Healthcare NHS Foundation Trust in March 2019 and concluded that its overall rating had fallen from good to requires improvement.

Rampton Hospital is part of the forensic service directorate which consists of high, medium and low secure services. We carried out an inspection of the medium and low secure wards in March 2019 and rated them as requires improvement overall and as inadequate in safe, good in caring and effective and as requires improvement for responsive and well led.

High secure services are inspected and rated separately from low and medium secure services. We last 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). The report that followed this inspection stated the provider must make improvements in nine areas

We carried out 20 Mental Health Act monitoring review visits between April 2018 and March 2019.

How we carried out this inspection

On 4 June 2019 we observed a carers day and spoke with five carers. We also attended a patient council meeting on 8 June 2019.

On 11 to 13 June 2019 we carried out a thematic Mental Health Act review visit to look at seclusion and long-term segregation. During this review we spoke to 48 patients, 38 staff and looked at 27 patient records.

On 14 June 2019 we carried out interviews and focus groups involving 123 staff representing nurses, healthcare workers, speciality doctors, consultants, associate medical director, clinical director, psychologists, occupational therapists, modern matrons, ward managers, security hospital site managers, head of security, and a range of disciplines. On this day,

Summary of findings

Healthwatch carried out patient interviews and shared their findings with us. Healthwatch is a statutory agency intended to strengthen the collective voice of users of health and social care services and members of the public, both nationally and locally.

During our inspection between 2 and 4 July 2019 we:

- spoke with 94 nursing and multidisciplinary team staff members

- spoke with five members of the senior leadership team
- spoke with 54 patients
- looked at 66 patient care and treatment records
- looked at the medication charts for 37 patients.

After our inspection, between 9 and 12 July 2019 we carried out telephone interviews with eight carers.

What people who use the provider's services say

The majority of patients told us they were concerned about shortages of staff and how this impacted on their access to fresh air and activities. They expressed concerns for staff wellbeing and staff not being able to take breaks.

A minority of patients reported concerns about staff attitude. For example, patients we spoke with in the women's service told us staff provoke patients and a patient on Erskine ward told us there was a coercive atmosphere with staff unduly asserting their power over patients. Some patients said staff used or condoned the use of racist language. This is of particular concern in a high secure environment.

One carer expressed concern about staff lacking basic cultural awareness of the patient's background and a lack of involvement of carers from different ethnic backgrounds.

A minority of patients raised concerns about involvement. For example, a patient on Adwick ward reported staff did not listen to them and they did not have input into their care plan. Some patients said they were not always clear what they had to do to progress within their pathway.

The majority of patients said staff were supportive, listened to them and treated them well and behaved appropriately towards them.

Seven of the eight carers we spoke with told us staff were friendly, approachable and supportive when they came to the hospital to visit. Carers said the children's centre provided very good facilities for children to visit.

Good practice

We found the following good practice:

- Staff supported patients to have visits from their family members on the ward. This enabled families to see how their relative was living.
- The hospital was introducing Digi-Dialectical Behaviour Therapy. This was to enhance the therapy programme and provide patients with interactive resources directly through their personal television to support them to practise skills.

- The hospital had a cycle track and outdoor fitness equipment for patients with grounds access. An Annual Health and Fitness Award ceremony took place to celebrate the achievements of patients over the year.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- 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.

Action the provider SHOULD take to improve

- The hospital should ensure all staff are aware of the ligature risk assessment for the ward they are working on. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital should ensure staff in care programme approach meetings discuss how to support patients to come out of long-term segregation and reintegrate into the ward.
- The hospital should ensure they continue to monitor incidences of lone working at night and take steps to eliminate it.Regulation 18 HSCA (RA) Regulations 2014, Staffing.
- The hospital should ensure staff support patients to set goals as part of their care planning and that care plans are detailed and holistic. Regulation 9 HSCA (RA) Regulations 2014 person centred care.
- The hospital should ensure staff understand when patients require mental capacity assessments for decisions not relating to their consent to treatment, such as finances. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital should ensure they continue to take actions to improve medical engagement in management decision making. Regulation 17 HSCA (RA) Regulations 2014, Good governance.
- The hospital should ensure staff have access to regular and effective clinical supervision. Regulation 18 HSCA (RA) Regulations 2014, Staffing.
- The hospital should ensure all hand gel dispensers throughout the hospital contain hand gel. Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment.
- The hospital should consider improving the systems to respond to alarm activation.
- The hospital should consider improving the cleanliness of kitchens and patient fridges.
- The hospital should consider making rooms available for staff to take breaks.
- The hospital should consider when staffing concerns should be escalated to bronze, gold or silver command.

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	RHA04

Mental Health Act responsibilities

The hospital had trained 80% of staff in the Mental Health Act. Staff we spoke with 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.

Patients had easy access to information about independent mental health advocacy. Advocates supported patients on during ward rounds and attended community meetings when possible.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand. This also included information given and displayed about section 134 mail monitoring.

The hospital had clear processes to monitor patients' mail, in line with section 134 of the Mental Health Act. However, there were occasions when staff were unable to review patients' mail within the specified seven-day timeframe and this caused delays in patients accessing their mail. We saw examples of staff supporting patients to understand why staff monitored their phone calls.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this has been granted. All patients had leave for medical treatment.

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 stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them.

Care plans referred to identified section 117 aftercare services and section 117 aftercare planning meetings took place on the wards.

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

In our last inspection, we found seclusion and long-term segregation reviews were not undertaken in accordance with the Mental Health Act Code of Practice. Our Mental Health Act review of seclusion in June 2019 found the hospital had further improvements to make.

Mental Capacity Act and Deprivation of Liberty Safeguards

Although the hospital had trained 78% of staff in the Mental Capacity Act, staff did not consistently demonstrate a good understanding of the Mental Capacity Act, in particular the five statutory principles.

Staff regularly considered and reviewed patients' capacity to consent to treatment. However, staff across the hospital did not demonstrate a competent understanding of when a patient 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 especially on the wards for people with a learning disability.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We saw examples of how staff made decisions in a patient's best interests, including when using mechanical restraint.

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. The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Are services safe?

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

Inadequate 🔴

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

Our findings

Our rating of the safe domain went down. We rated it as inadequate because:

Safe and clean environment

- Not all wards were safe, clean and fit for purpose. However, they were well equipped, well furnished and well maintained.
- 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. However, three staff reported sometimes feeling unsafe at times when completing observations alone in corridors where they were unable to be seen by other staff.
- Not all staff we spoke with were aware of their own ward's ligature risk assessment and there were not always hard copies available on wards of for staff to view. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. On Alford ward two staff members we spoke with did not know what a ligature risk assessment was.
- Staff alarms did not always work effectively and when they worked other staff did not always respond promptly. Although staff had easy access to personal alarms, some told us that when two staff activated their alarms at the same time, they cancelled each other out and the alarms were not activated.
- Staff in our focus groups said the time taken to respond to alarms was variable due to escalating staffing pressures. Staff told us, and we saw, that staff were not allocated at the start of the shift to respond to alarms across the hospital. Instead, staff said that whoever was available would respond to alarms. This presented a risk that all staff might be engaged in clinical activity and therefore be unable to respond. Staff described occasions where an alarm had been pulled and there had not been a sufficient response from staff across the hospital. However, during the inspection we saw adequate numbers of staff responding to alarm calls in a timely manner.

- Response to patient nurse call systems was not always timely due to staffing pressures. Patients had easy access to nurse call systems on all wards and in all bedrooms. Staff personal alarms indicated when patients called for assistance from their bedroom.
- Between January 2018 and April 2019, 87% of staff completed training in hospital life support, which included how to use ligature cutters. Managers developed and updated ligature risk assessments to identify potential ligature anchor points on each ward. Risk assessments recorded the controls in place to reduce the risk of ligature incidents. On Alford ward and Bonnard ward, we saw that bathrooms had ligature risks. To reduce the risk of ligature incidents, staff allowed only one patient at a time to access these bathrooms and supervised patients closely.
- Staff did regular environmental assessments of the care environment. During our last inspection we found fire doors had been left open. Fire doors were now closed throughout the hospital. Staff displayed local fire safety information and procedures in the nursing office and 88% of staff had completed mandatory fire safety training.
- The design of patient bedroom and bathroom doors prevented self-harm through holding, barring or blocking. Doors and windows in rooms had observation panels with either integrated blinds or curtains on the outside of rooms.
- All wards were single-sex and therefore complied with the Department of Health's guidance on same-sex accommodation.
- The trust had a refurbishment plan to ensure the hospital and its grounds remained safe, secure and fit for purpose.

Security

- Frequent staff redeployment and staff shortages posed a potential risk to disrupting staff patient relationships. Physical security includes fences, locks, personal alarms. 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. Procedural

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security is the policies and procedures in place to maintain safety. Safety of the wards relied on staff relationships with the patients and their adherence to the hospitals policies and procedures.

- The security level in a high secure hospital equates to a Category B prison to prevent escape from within the secure perimeter. The head of security confirmed there was enough resource to maintain security of the hospital. The hospital had a team of 14 hospital site and security managers for maintaining the safety and security of the site. No patients had absconded from the hospital.
- 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. Staff completed mandatory training to maintain security. This had been achieved by 92% of staff.

Maintenance, cleanliness and infection control

- Not all ward areas were clean. We found a sink full of dirty water in the clinic room on Adwick ward. We saw bin bags piled up in the ward sluice cupboard, empty food tins stacked on the floor of the kitchen waiting to be collected and food items dripping onto the kitchen floor. On Alford ward, a fridge containing patient's food was dirty. We did not see the cleaning records for these wards as these were not available.
- There were issues with access to quiet rooms on women's service for staff to take breaks. Staff told us there was nowhere on the ward they could go to eat on their break and had experience of a manager berating them if they found staff eating on the office. Staff rooms in the women's service were provided off the ward, but staff reported issues with finding time to access these areas.
- Staff followed the infection control policy including hand hygiene.
- We found that several hand gel dispensers throughout the hospital were empty. On Ruby ward, staff carried out a hand hygiene audit five times per month. This internal audit by staff captured and addressed non-compliance with required standards. For example, we looked at the audit for the 2 July 2019 and saw that three staff had not been compliant due to nail varnish or rings. Data showed that 95% of nursing and medical staff had completed hand hygiene training.

- Since the last inspection the hospital's infection prevention and control team had undertaken monthly infection prevention and control audits and provided advice to staff. We saw examples of how this audit had led to changes within the hospital, including new equipment for clinic rooms.
- We saw information about infection prevention and control displayed around the hospital on noticeboards to remind staff of the key principles. The hospital had recently carried out an investigation following an infection control incident involving putting a ward into quarantine due diarrhoea and vomiting outbreak. The hospital acted immediately managing the outbreak well.
- Between January 2019 and June 2019 there was one recorded incident of sepsis at Rampton Hospital. Between May 2018 and May 2019, the trust trained 94% of staff in level one infection control, including sepsis.
- Carers we spoke with told us that when they visited patients on the wards, the environment appeared clean and well maintained.
- At the time of our inspection, the hospital had not completed their Patient-Led Assessment of the Care Environment reviews for 2019 because these were delayed nationally. The hospital's 2018 Patient-Led Assessment of the Care Environment score for cleanliness was 96.5%.
- Wards had good furnishings and were well-maintained. We observed that furniture was heavy and bolted to the floor to avoid patients using items of furniture as a weapon. The hospital's 2018 Patient-Led Assessment of the Care Environment score for condition, appearance and maintenance was 92.1%.

Seclusion room

- Not all seclusion rooms allowed clear observation and two-way communication. They had toilet facilities and a clock, apart from Ruby ward where there was no clock outside of the seclusion room, which meant that patients in seclusion could not orientate themselves to time.
- There was a blind spot in the seclusion room on Bonnard ward. Staff told us they had asked the hospital to position a mirror by the blind spot to allow staff to observe all areas of the room from the viewing area. We raised this concern during our inspection and the hospital took immediate action to address it.

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Clinic room and equipment

- The hospital did not always maintain clinic room temperatures at the right level. For example, on Quantock ward there were nine occasions in May 2019 and four in June 2019 where the room was above 25 degrees. This temperature was too high. The quality and effectiveness of medicines can be affected by changes in storage temperatures.

- There was no air conditioning in clinic rooms on the wards for people with a personality disorder. Staff used a fan to try and lower the temperature. However, the fan was dirty, and this was an infection control hazard. A pharmacy audit identified four missed temperature recordings in June 2019. On Coral ward nursing staff raised concerns to pharmacy on 24 June 2019 following several occasions throughout May and June where the room temperature exceeded 25 degrees. Pharmacy staff told ward staff they did not need to take action but on 3 July 2019 pharmacy advised the nursing team to introduce a fan in to the room to reduce the room temperature.

- The hospital had fully equipped clinic rooms with accessible resuscitation equipment that staff checked regularly. They had accessible emergency medicines, as required by the Resuscitation Council, that were available on every ward.

- During our inspection, on Quantock ward, we found the tag on the emergency medicines bag was missing. We raised this with staff who immediately removed the bag to rectify the issue. Staff had resolved this before we left the ward. The hospital had recently changed its process for checking the emergency equipment bags and had allocated this responsibility to the physical health centre staff. Physical health centre staff checked the emergency bags monthly and placed a tag over the bag to indicate it had not been tampered with since the previous check.

- Supplementary medicines were stored securely in a cupboard on Alford ward. Staff told us it could take up to twenty minutes to access these medicines on Alford ward from the wards on the other side of the hospital site. Staff had to check online that these additional medicines were available and phone Alford ward. When they needed to check or restock these supplementary medicines, staff from Alford ward were required to take the bag to the physical healthcare centre and this had an impact on staffing pressures on the ward.

- The hospital had plans to move the supplementary medicines to Cambridge ward which was more central than Alford. They said that they had timed how long it took to access the medicines from all wards and felt the time was acceptable. We could not evaluate the effectiveness of this.

- Staff maintained equipment well and kept it clean. 'Clean' stickers were visible and in date. There was suitable equipment in the physical healthcare centre with dedicated rooms for dental and optical care and this appeared to be clean and well equipped. For example, we saw a self managed digital machine that could measure height and weight outside the consultation rooms. However, on Adwick ward, we found staff had not completed physical health monitoring of one patient on three occasions due to a large blood pressure cuff not being available.

Safe staffing

- The service did not have enough nursing, medical and multidisciplinary staff. We issued the hospital with regulatory notices about staffing following our inspections in 2017 and 2018. We also raised concerns about staffing following two inspections in 2016. During all of our 20 Mental Health Act monitoring visits during 2018 and 2019, staff and patients consistently raised staffing concerns, and these were repeated in the June 2019 seclusion and long-term segregation review. Staff raised short staffing as a key theme during our focus groups in June 2019.

- During this inspection, 84% of nursing staff, 87% multidisciplinary staff and 70% of patients raised staff shortages as a concern

- The hospital did not have the appropriate skill mix and staffing establishment despite using national tools and benchmarking to review staffing levels.

- Staffing the hospital was a complex issue requiring a lot of movement of staff to fill in shortfalls. The hospital security site managers had good overview of staffing demands and activities across the site. However, they told us they were not effectively used to manage and provide solutions to staffing challenges. 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.

- Senior managers acknowledged that ward staff still felt wards were understaffed despite the hospital recruiting

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more staff since the last inspection. This was due to an increase in the amount of support patients needed such as;- enhanced observations, long-term segregation and seclusion.

- Staff said the largest impact on staffing levels was out of grounds leave combined with ward staff shortages resulting in a significant shortage of staff within the hospital. Out of grounds leave is when a patient leaves the hospital site for court appearances and medical leave. Each patient required between three and eight staff escorts. Between January and May 2019 there were 332 planned medical leave appointments. Between April 2018 and March 2019 there were 194 incidents of emergency medical leave. Staff were re-deployed from wards to meet escort requirements.

Nursing staff

- The hospital ratio of qualified nurses to healthcare workers was low resulting in a dilute skill mix, less experience teams and gender imbalance on wards. There were 1274 substantive whole-time equivalent staff in post at Rampton Hospital. Of these, 28% (361) were registered nurses and 48% (606) were healthcare assistants. The health care assistant posts were over establishment by 11%, to support qualified nursing vacancies. On 3 July 2019 we saw one ward with more female staff than what had been determined as safe due to risks of assaults to females specifically.
- The vacancy rate was high at 16% for nursing posts. The women's service had the highest vacancy rate (26%), followed by personality disorder services (22%) and learning disability services (19%).
- The sickness rate was higher than the national NHS average (4.08% in March 2019). Between June 2018 and June 2019, the hospital's average staff sickness rate was 7.1%. Personality disorder and learning disability services had nursing sickness rates greater than the hospitals average. The learning disability service and the therapies and education department had healthcare assistant sickness rates greater than the hospital's average. Managers performed return to work interviews with staff following periods of sickness.
- The hospital had a high annual staff turnover rate of 13%. Between June 2018 and June 2019, 174 staff left. The hospital had an aging workforce; 25% of the staff who left had retired. Staff turnover was higher for healthcare assistants (15%) than qualified staff (11%). Mental health, personality disorder and learning

disability services had turnover rates greater than the hospitals average. The women's, learning disabilities, mental health and personality disorder services all had annual average turnover rates of between 13% and 17%. They had in post stability rates between 74% and 84% (the proportion of staff left in post with more than 12 months service). Between 1 June 2018 to 31 May 2019 the hospital had an average qualified nurse staffing gap of 22.3% due to vacancies and sickness.

- Bank shifts could not be consistently filled. Managers deployed bank nursing staff in an attempt to maintain safe staffing levels. The hospital had its own bank of nursing staff who received an induction and were familiar with wards. Between May 2019 and June 2019, bank staff filled 3% of budgeted qualified nurse hours and 5% of budgeted healthcare assistants hours. In the same period, 7% of healthcare assistant hours remained unfilled. The hospital did not use agency staff to fill qualified nurse or healthcare assistant hours.
- 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. However, staff and patients reported that while shifts often started with enough staff to support patients' needs, staff members could be moved immediately to support other wards.
- Lone working at night continued to occur. During previous inspections, we have raised concerns about lone working practices. The trust had taken actions to reduce the episodes of lone working. Although occurrences had decreased, between January and May 2019, there were 32 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. One patient with diabetes told us that lone working at night meant waiting to have blood sugars checked.

Impact of staffing pressures on patient care and treatment

- We concluded current staffing figures were insufficient to support the care and treatment needs of the patients at the hospital. This was because although the data around staffing appeared to demonstrate there were enough staff, this was unanimously contrary to the experience of staff and patients.

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- During the inspection, we saw many examples of how staffing pressures impacted on patient care and treatment. This included delays in staff meeting the needs of individual patients, staff unable to meet the needs of multiple patients at the same time and staff unable to review patients care and treatment.

- For example, on 5 June 2019 Aintree ward staff recorded they were unable to review patients' care plans due to staffing shortages. We saw records for a futher four examples of reviews being cancelled due to low staffing levels

- We saw examples of actual staffing levels failing to meet planned levels. On 4 July 2019, Quantock ward staff reported there should be eight staff on duty to meet their current clinical demand. However, we found only six staff present.

- Care and treatment records documented 26 examples of when low staffing numbers impacted on what staff could offer patients. Between 18 April 2019 and 31 May 2019, one care and treatment record from Ruby ward recorded eight occasions of activities and time out of segregation being cancelled due to short staffing.

- Patients we spoke with said wards sometimes felt unsafe and there were not enough staff to meet their needs. We saw Quantock ward patients had raised concerns about staff shortages with staff during a community meeting in July 2019.

- Patients said staffing had a negative impact on their daily tasks and meeting physical health needs. For example, staff assistance to empty a stoma bag or access to toilets at mealtimes.

- Hospital data did not match the experience of staff and patients. The trust provided data to show all clinical services offered patients an average of 25 hours of activity per week and that staffing issues accounted for less than 1% of planned activity session cancellations. However, of the patients spoken with 78% described how staff shortages impacted on their access to activities and fresh air and described frequent cancellations. This meant that patients were at times kept on the wards without access to therapeutic activities.

- Patients reported lack of access to fresh air. Between March and May 2019, staff offered patients 22,448 hours of fresh air. This accounted for 61% of the target. Access to fresh air was lowest in the women's services where staff offered patients only 34% of the targeted hours.

- Staff confirmed to us that staffing levels did not always allow patients to have regular one-to-one time with their named nurse. Minutes from a recent community meeting on Newmarket ward recorded a patient's concern that as a result of staff being taken from the ward, they were unable to have one to one time with their named nurse.

- Of the nursing staff we spoke with 60% reported regular staff moves as disruptive to the care and treatment of patients. For example, between 22 May and 2 July 2019, staff had been moved from Newmarket ward on 23 of the 42 days. This included moves to different clinical services. This impacted on staff skill mix in each clinical service. Staff said different skills and approaches were required in providing care and treatment to patients in different clinical services.

- Staff did not get regular breaks from observations. For example, on Coral ward one staff member was asked to complete one to one observations with different patients for four and a half hours 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.

- Staff locked off areas of wards so that patients could not access them or confined patients to their rooms resulting in restriction of movement. This was to ensure safety during periods of staff shortage. Care and treatment records confirmed this. Between 1 March and 30 June 2019 there were 44 recorded occasions when staff closed off areas of a ward or confined patients to their bedrooms. On 25 May 2019, the hospital's site manager instructed that all patients subject to long-term segregation must remain in their room all day. Between 1 January 2019 and 31 May 2019, there were four occasions where staff kept patients in night time confinement for longer than the time outlined in the trust's policy.

- On 29 June 2019 there was an overall shortage of 57 staff across the hospital. As a result, the hospital put Adwick ward on lockdown and deployed staff elsewhere

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within the hospital. This meant staff kept patients locked in their bedrooms from 4pm until the end of night time confinement at 8am the following morning. This restricted patient movement around the ward, impacted on their wellbeing and ability to access therapeutic activities and fresh air.

Impact of staffing pressures on staff

- Staff worked overtime to try and maintain safe staffing levels. A health roster recorded the number of hours staff worked. Between March and May 2019, 146 staff worked more than 48 hours per week on 391 occasions. Staff in the women's service accounted for 36% of recorded overtime. In June 2019 Hambleton ward recorded 657 overtime hours staff said this was the average per month. Staff required manager approval to work more than 65 hours overtime in a month.

- Staff reported they were not always able to take annual leave when they wanted it and at times the trust cancelled leave. The hospital disputed this and reported that, between April and June 2019, they had not cancelled any staff annual leave.

- Staff shortages impacted on staff taking breaks and not having time to go to the toilet. Staff reported being tired and at risk of "burn out". Patients on the women's wards voiced concerns about staff wellbeing. This included examples of staff being physically unwell due not taking meal or toilet breaks. The majority of nursing staff worked 14 hours shifts from 7.30am to 9.30pm.

- The central resource office deployed staff across the hospital to maintain safe staffing levels on wards. Staff referred to this practice as 'loans'. Between December 2018 to May 2019, a total of 19,864 hours were 'loaned' from one ward to another. Of these staff loans 56% (8673 hours) were within the same care stream. Staff reported the hospital moved newly qualified staff, or that by moving experienced staff it left wards with an inexperienced team. Staff reported this was especially an issue in the women's service. Staff reported that they feared speaking up about staffing concerns in case the hospital moved them to work on wards they were unfamiliar with.

- Staff working in high secure hospitals used to receive a pay enhancement this ceased due to cost improvement programmes. Staff believed the loss of this enhancement made recruitment and retention more difficult. Newer staff recruited without a pay enhancement worked alongside established staff who still did. Staff regarded this disparity as unfair and a negative impact to retention and morale. However, the trust had analysed the high secure pay enhancement and found that staff who received it left as frequently as those who did not.

Steps taken by the trust to address the staffing pressures

- The hospital had several challenges related to staff recruitment and retention. Rampton Hospital is rurally located and has an aging workforce with 25% of staff approaching retirement age. It is competing with other providers against a national shortage of registered mental health nurses and learning disability nurses.

- The hospital had a robust recruitment strategy. This included a dedicated recruitment and retention modern matron and a range of other initiatives. For example, expert recruitment training from another trust, assessment centres for healthcare assistants, bespoke recruitment campaigns and relocation pay. To try and reduce the loss of newly qualified nurses, the trust made monthly contact with nurses who had accepted an offer of employment and were waiting to start work. The hospital also participates in the second wave of the NHS Improvement Retention Workstream.

- Because of the acuity of the work on psychiatric intensive care units, the trust did not allocate new starters to work on them or to move new staff to work on different wards within the first three month of starting. However, staff in focus groups told us this still happened.

- Between June 2017 and June 2019, the trust successfully recruited 48 newly qualified nurses for the preceptorship programme within Rampton Hospital. A wellbeing champion interviewed new starters every three and six months as part of the staff retention plan.

- There was a comprehensive local induction programme for new employees.

- Between March 2018 and March 2019, the hospital supported the development of 37 trainee nurse associates. A nursing associate role aims to help bridge the gap between health care assistants and registered nurses. The Trust had also seconded 12 staff to complete their registered nurse training.

- Some staff who retired returned to work at the hospital in various roles. This included offering mentorship to new staff.

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- Between June 2018 and June 2019, the executive director of forensic services carried out 64 face to face exit interviews and seven phone calls with staff who had left their job. This was to understand staff's reasons for leaving. The trust also used an external agency to hold exit interviews with staff leavers.

Medical staff

- Consultant psychiatrist caseloads at Rampton Hospital were higher than those of the other high secure hospitals. Doctors reported the impact of this meant they could not effectively engage in managerial decision making about Rampton Hospital. We reported concerns about medical caseloads during our last inspection. The hospital employed some locum consultants to support the reduction in caseload whilst the hospital recruited permanent consultants.
- Between June 2018 and June 2019, medical staff vacancy rates were high (20%). For example, because Cheviot ward had been without speciality doctor cover for five months, staff relied on the support of the duty doctor.
- Between 1 June 2018 and 31 May 2019, agency staff filled 5400 hours of medical staffing hours and 115190 medical hours remained unfilled at Rampton Hospital.
- Medical staff provided cover day and night and a doctor could attend wards quickly in an emergency.
- Speciality doctors reported out of hours workloads were high. At weekends, it was difficult to carry out the seclusion and long-term segregation reviews and physical health assessments. Minutes of speciality doctor meetings showed they had raised their concerns with senior managers. Rotas showed there were two speciality doctors for the hospital Monday to Friday and one at weekends.

Therapies and education staff

- Social workers, psychologists, speech and language therapists and occupational therapists had caseloads of 25 patients to one staff member. This was higher than similar professionals' caseloads at the two other high secure hospitals. This meant members of the multidisciplinary team were not always able to attend ward round reviews and there were waiting lists for patient to access therapeutic activities.
- All occupational therapists and speech and language therapists were used to cover ward staffing deficits and therapy technical instructors often cancelled sessions to make up ward numbers. Following direction from their managers, since 2018 therapy staff did not report these occurrences as incidents.
- Occupational therapists, psychologists and social workers told us their workload hindered their capacity to do their roles fully. Occupational therapists did not feel part of the clinical team and felt reprimanded by senior hospital managers. Social workers believed it delayed their provision of specialist safeguarding support and advice to nursing staff. Psychologists said it hindered implementation of formulations and supporting reflective practice to staff.
- Therapy staff reported that communication with patients when sessions were cancelled was poor. This impacted on therapist's relationship with patients.
- The therapies and education department did not have as many staff as it was budgeted for. The department had a budget for 142.5 whole time equivalent staff but only had 120 whole time equivalent staff in post. According to data submitted by the trust, between March and May 2019, the therapies and education department cancelled 1290 hours' worth of activity. The primary reasons for closures were staff shortages, sickness and annual leave. Unplanned maintenance work to a roof space in the department during May and June 2019 also impacted on closures.
- The medical director commissioned a review of the trust's clinical and forensic psychology staffing structure and leadership. The review recommended the trust introduce a strategy to address its workforce shortfalls to ensure that psychology provision met the recommended standards.

Mandatory training

- The trust provided staff with mandatory training. The hospital's overall mandatory training compliance rate as at 31 May 2019 was good at 90%. This had improved since our last inspection. However, staff reported the hospital took them off mandatory training regularly to maintain safe staffing numbers on the wards. We reviewed data in relation to this and found the hospital had cancelled three mandatory training sessions between 1 March and 31 May 2019, affecting 54 staff. In all instances referred to above, staff were informed of what training they had missed and rebooked onto training courses.

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Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed risk assessments on admission and updated these regularly. We looked at 66 care and treatment records across the hospital. In all but one of the records we looked at a risk assessment was present and complete. We raised concerns about the one record with missing information with the clinical team during our inspection and have since received assurance that staff have completed this. Staff used a recognised risk assessment called the Historical and Clinical Risk Management tool which is a comprehensive set of professional guidelines for the assessment and management of violence risk. At the time of our inspection the hospital was in the process of reviewing the Treatment Risk Information Management System to incorporate this into the electronic care planning and reduce duplication.
- We saw evidence in all but one of the care and treatment records that patients' risk assessments informed their care plans and staff had ensured the documents were linked. We noted one example on Burne ward where a patient's risk assessment did not inform their risk care plan and only contained information related to the risks associated with night time confinement.

Management of patient risk

- We noted inconsistency in how and when staff recorded patients' allergies. There was no system on the patient electronic record system to alert staff to patient allergies. On occasions staff had not completed the patients' allergy indicator card in their healthcare file, despite them having known allergies. Staff we spoke to on the women's directorate were unaware of how they would know about patient allergies.
- Staff did not consistently identify and responded to changing risks to, or posed by, patients. In our last inspection we found that staff had not totalled National Early Warning Scores consistently or escalated them for medical advice. During this inspection, we found that whilst there had been some improvements shown by audits in the use of the tool, not all wards consistently added up the scores or escalated for action when trigger scores indicating physical ill health were reached.

- We saw an example of where a patient had returned to Rampton Hospital, after receiving treatment in an acute hospital and staff did not complete their physical health observations for two days.
- Staff did not consistently follow policies and procedures for use of observation, including to minimise risk from potential ligature points and for searching patients or their bedrooms.
- The trust had an observation and engagement policy. Following our inspection in August 2016, we reported on actions the provider should take to improve observations. This included ensuring all staff on night shifts should get breaks from continuous observations and should review their baseline numbers of staff to determine the adequate numbers required to maintain safe staffing to meet therapeutic care and treatment. The trust received a warning notice about observations in 2016.
- During our inspection we found that staff were not completing observations at irregular intervals in line with trust policy. For example, we found that on Ruby ward night time confinement observations between 01 and 04 July 2019, staff recorded observations exactly every half an hour for all 13 patients.
- Staff said that they did not get breaks when undertaking observations, we had raised this at previous inspections. Staff on Ruby and Alford wards said they completed one to one patient observations for four and nine consecutive hours, respectively. We saw examples of this in shift planners we reviewed on the wards and saw that although staff did rotate between different patients, there were occasions where staff were completing continuous one to one observations of patients for several hours. This was against National Institute for Health and Care Excellence guidance.
- The hospital senior management team were in the process of piloting the use of zonal observations on some wards. They proposed this would reduce the burden of enhanced observations on ward staffing numbers. This is an approach in which the hospital assigns staff to observe and engage with patients within specified zones within the ward area. It would mean patient's having limited movement within the area to allow for constant supervision by staff.
- Staff searched patients every time they re-entered the ward. Staff also made searches of the ward and patient bedrooms. However, the minutes of the 18 May 2019 Emerald ward staff business meeting documented that

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staff had not completed communal area searches since 4 May 2019. On Aintree ward, staff did room searches at a frequency determined by clinical risk assessment. Staff had not been able to complete nine planned room searches by the end of the month due to short staffing.

- The term blanket restrictions refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application (Mental Health Act Code of Practice, 2015). When there were staff shortages patients were subject to early confinement to bedrooms, or specific areas of the ward to maintain safety. A consequence of this was to restrict patients' freedom. This was a blanket restriction. The hospital had a restrictive practice group and the patient's council regularly discussed restrictive practice.

- Staff were aware of and dealt with any specific physical health risk, such as falls or pressure ulcers. Physical health nurses undertook falls assessments and a tissue viability nurse specialist provided advice.

- Staff kept a clear inventory of each patient's restricted items. We looked at patients' signing in and out sheets for restricted items on Burne ward and saw that these were up to date and accurate.

- During our inspection we observed ward round meetings on Burne, Brecon and Cheltenham wards. We saw in each meeting that the clinical team considered the patients' current level of risk in their clinical decision making. We saw evidence of safe positive risk taking to promote patients' progression in their treatment pathway and if the team were unable to meet the patients' requests to reduce or remove a restriction, they provided a clear rationale for this decision.

- Staff assessed patients' access to items and reviewed this regularly to ensure least restrictive practice.

- Staff adhered to best practice in implementing a smoke-free policy. The trust had an established system in place to allow ambulances and emergency vehicles to safely access the hospital's wards when required.

Use of restrictive interventions

- The trust had a seclusion and long-term segregation policy dated March 2017. They reviewed this in March 2018 and it was due for further review in January 2020.

- The Mental Health Act Code of Practice defines seclusion as: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others'.

- Since our last inspection, there had been a decrease in the use of seclusion and long-term segregation. Between 01 April 2018 and 01 April 2019, the main reason for seclusion was disruptive behaviour. Out of 744 seclusion incidents, the highest type of incident was due to violence to staff (328) followed by violence to patients (132). The highest number of incidents were in the personality disorder and the learning disability service. The wards with the most patients using seclusion were Kempton, Aintree, Brecon, Blake, Cheltenham, Cheviot and Topaz. During this period 153 patients were secluded. 111 patients were secluded more than once. There were 591 repeat seclusion incidents. 447 seclusion episodes lasting 24 hours or longer.

- 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'.

- Sixty-two patients had been subjected to long-term segregation. Forty-four of these patients had been in long-term segregation less than one year, two for one year, seven between one to two years, four between two and three years, one between four and five years, three between six and seven years, and one patient for more than seven years.

- We observed a care programme approach meeting on Brecon ward for a patient in long-term segregation in which limited discussion of how staff could support the patient to come out of long-term segregation and reintegrate on the ward occurred. The team did not develop or discuss a plan for the next six-month review period. We saw that the meeting was well attended by all members of the multidisciplinary team.

- 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.

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- There was an increased use of mechanical restraint. Between 1 June 2018 to 31 May 2019 there were 403 uses of mechanical restraint which was an increase of 5.5% compared with 1 June 2017 to 21 May 2018 where there were 381. Mechanical restraint involves any device that restrict a patients' free movement and it is most commonly used in emergencies to protect the patient from self-harming. There were good governance processes in place to make decisions about its use. The Mechanical Restraint Interventions Governance Group reviewed mechanical restraint to reduce its use wherever possible.

- There was an increase in the use of restraint. There were 1878 episodes of restraint between 1 June 2018 to 31 May 2019. This was an increase of 31.7% compared with 1283 restraints in the previous year. Restraints were highest in the learning disability and women's services such as Aintree, Cheltenham, Kempton, Coral, Emerald and Topaz wards. Between 1 June 2018 to 31 May 2019, the number of individual patients that staff restrained was 589. This was an increase of 66.5% on the previous year, when staff used restraint with 200 individual patients.

- There was an increase in the use of prone restraint. There were 536 incidents of prone restraints in 1 June 2018 to 31 May 2019, this was an increase of 13.8% from between 1 June 2017 to 31 June 2018 when 462 prone restraints occurred. These were highest in the women's and wards for people with a learning disability.

- There was an increase in rapid tranquilisation use. Between 1 June 2018 to 31 May 2019, there was 263 instances of restraint during which staff administered rapid tranquilisation. This was an increase of 23.2% on the previous year, which recorded 202 instances.

- Staff did not always follow National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Staff did not review the effects of each patient's medication on their physical health in line with National Institute for Health and Care Excellence guidance. We saw that on four occasions, staff did not follow guidelines after the administration of medicines to manage the patients' violence and aggression.

- All wards participated in the trust's restrictive interventions reduction programme. We saw staff frequently considered the option to reduce enhanced observations to reduce the use of restrictive interventions.

- We saw initiatives to reduce restrictive interventions. Staff reviewed this frequently and saw gradual reduction in long-term segregation. All staff had training on harnessing opportunities, protective enhancement system known as the Hope model. Elements of the Hope model had helped to reduce long-term segregation. The hospital adopted this model from another high secure hospital that had supported multidisciplinary teams to help patients move beyond long-term segregation.

- Staff reduced restrictive practice on Aintree ward by splitting the ward into two areas based on the patients' level of dependency. This enabled staff to separate the level of risk between the two sides of the ward. Staff then reduced the restrictions on the side of the ward where patients had lower levels of need, for example by putting condiments out on the dining tables for patients to use during meals. Topaz ward limited patients' access to bedrooms during meal and medication time to mitigate risks.

- 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 had made patients aware of the reason for the restraint and provided them with a debrief after the event. Patients in the learning disability service were especially positive about how staff managed the use of restrictive interventions. However, two patients on Cheviot ward raised concerns about how staff used restraint and reported it had been painful.

Safeguarding

- The Trust employed dedicated specialist safeguarding leads trust wide including one full time post at Rampton Hospital. The operational work was led by the social care service at Rampton Hospital. The primary resource for safeguarding was the dedicated safeguarding team.

- Staff highlighted the need for improved safeguarding training. Staff told us the trust's safeguarding training did not suitably equip them for working in high secure hospital setting. Staff believed the training was more suited to staff working in community and less secure mental health settings. Instead, staff relied on advice and guidance from the hospital social work team, whom staff reported were approachable and accessible.

- Staff knew how to make a safeguarding alert however they did not do so consistently. Members of the social

Are services safe?

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

work team raised concerns that staff did not consistently raise safeguarding alerts as required, particularly at times when staff felt they may not have had enough evidence. The social work team described the work they had completed with nursing staff to support them to identify when to make a safeguarding alert and noted some improvements since implementing this additional support.

- Social workers led on safeguarding in the hospital. Nursing staff reported positive relationships with the social workers. Social workers reported positive relationships with the local authority safeguarding team.
- Staff provided examples where the clinical team had met as part of a safeguarding awareness meeting to discuss and review patients' risks and when a patient had been in long-term segregation, how the team had developed multidisciplinary plans to reintegrate patients onto the ward.
- We reviewed a patient's safeguarding plan. It was simple to read and clearly identified the risks and what the clinical team should do to mitigate these risks. We noted the action the clinical team took was appropriate and timely.
- We reviewed the hospital's quarterly safeguarding report. It showed staff monitored common trends and themes and reviewed staff reporting patterns. The report accounted for changes to the structure of care streams within the hospital and acknowledged how this may impact on the number of safeguarding incidents.
- Staff provided examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The trust induction included a one and half hour session on equality and diversity. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.
- However, three patients on different wards reported that staff had condoned the use of racist language by staff towards patients and that staff did not challenge inappropriate or offensive language. We had also been told that staff did not adopt a zero-tolerance approach to racist remarks from patients or staff during our seclusion review. Patients asked us not to identify them as they feared it would affect their progress on their care pathway to less secure environments.
- Staff followed safe procedures for children visiting. Hospital social workers worked through a process of

checking the safety arrangements of children visiting. One carer gave positive feedback on child visiting facilities in the family visitors centre, saying they were exceptional and children were made to feel welcome.

- The trust had recently changed its policy to ensure the multidisciplinary team reviewed photographs brought in by family members for patients to keep on wards. This was to safeguard patients and the people in the photographs.

Staff access to essential information

- All information needed to deliver patient care was available to all relevant staff, including bank staff, when they needed it and was in an accessible form. This included when patients moved between teams. However, three staff members on the wards for people with a learning disability and women's services reported issues with access to computers and access to electronic notes.
- 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. The physical health centre completed physical health checks and wrote care plans. Staff then printed this out and kept this care plan with the single healthcare record. Within the Jasmine suite on Topaz ward, staff had access to an iPad which allowed staff to access the electronic system used by staff on the wards. Only medical staff and ward managers had access to the primary care record system from the wards.

Medicines management

- Staff did not follow systems and processes when administering, recording and storing medicines. We found medicines on one ward that were past their expiry date. The medicine was to control a patient's blood glucose level, and degradation of the medicine could have resulted in a loss of control of their blood glucose levels.
- The standard of medicines storage varied across the wards. We found 14 missing records of room monitoring temperature and fridges seen across two wards. We saw one example when staff had not recorded actions when the clinic room temperature exceeded the recommended storage temperature for medicines.

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- Patient photographs were missing on medication cards on Aintree ward. This meant that staff would not be able to cross reference that the medication was being administrated to the correct patient.
- Staff did not always sign for the administration of medicine. We looked at 37 prescription charts. We found 14 missing administration signatures, this included both a physical health medicine and mental health medicines. The physical health medicine was to help prevent breathing difficulties and it was unclear if staff had administered it on nine occasions. The others included a medicine used to prevent seizures and another in the treatment of psychosis.

Track record on safety

- Between July 2018 and July 2019, the hospital reported 89 serious incidents. Staff reported serious incidents via an electronic incident reporting system and senior managers in the trust reviewed incidents.
- The governance team did not summarise the outcome of incident investigations on the appropriate sections of the initial management report (formerly known as the 72 hour report). This meant an overview was not maintained. We found there was no clear recording of the impact of staffing. For example, whether there were adequate staffing levels at the time of the incident. However, the Trust reported that when staffing was found to be a contributory factor in incidents, it was clearly identified in the root cause analysis report.
- We reviewed five incidents and found the hospital had carried out investigations and implemented action plans. There was variability in lessons learnt.
- In one incident we reviewed, a patient barricaded themselves in a bedroom. To respond to this incident staff needed to use specialist personal protective equipment. This can include items like shields and helmets. At the time of the incident there were only four personal protective equipment trained staff on duty (the team needed a minimum of 9 staff with this training in this instance). Hospital managers contacted personal protective equipment trained staff to come in from home to attend the incident. Managers appropriately investigated this incident and implemented an action plan. However, there appeared to be no recommendation about the number of personal protective equipment trained staff that should be on duty across the hospital made as a lesson learnt in a high secure hospital.

- Staff were subjected to a high level of violence from patients. For example, in an incident reviewed a patient made an unprovoked assault on staff member in a position whereby the staff member was vulnerable and isolated. This resulted in the staff member sustaining significant injury. The hospital undertook a comprehensive root cause analysis investigation and notified the police as part of its zero-tolerance policy. Staff undertook reflective practice following the incident.
- Violence to staff was the main reason patients required seclusion. Between 1 April 2018 and 31 March 2019, this accounted for 328 of the 744 seclusion incidents recorded.
- Staff injuries resulted in 362 lost working days under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. This require employers to report specified workplace incident where they result in an employee being away from work, or unable to perform their normal work duties for more than seven consecutive days as the result of their injury. We found 18 violence related incidents reported under these regulations which had a root cause investigation.
- There had been one death at Rampton Hospital since the last inspection in which the hospital shared lessons learnt about Clozapine monitoring. We saw evidence of staff monitoring Clozapine on the appropriate wards. The physical healthcare centre undertook blood tests for Clozapine monitoring.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. However, 10% of staff we spoke with said they did not have time to report incidents due to short staffing.
- Between January and May 2019, incident analysis reports showed 84 incidents of low staffing. In the same period, staffing issues were recorded as attributing to 91 incidents of service disruption effecting clinical care, missed observations and an unsafe environment. This corroborated what staff told us, particularly in the women's service. For example, one staff member said, "I feel like we just feed and water patients, I feel unsafe going to work". A staff member from the men's mental health directorate described a "feeling of panic at all times".
- The trust offered staff debriefs and support after a serious incident, but this was not always offered in a

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timely manner or to the satisfaction of staff. A team leader was assigned to complete any necessary debriefs on every shift and staff called these sessions 'diffusions'. However, staff reported debriefs were sometimes rushed or delayed due to ward staffing pressures due to the need to get back out to support the ward. For example, staff reported that a debrief following a patient assault to staff was delayed for 20 days. Staff on Emerald ward described an incident on 22 June 2019 where a patient assaulted a staff member. The staff member did not receive a debrief until 12 July 2019. Staff reported psychologists used to facilitate reflective practice sessions to staff following serious incidents. However, psychologists reported they no longer had capacity to offer reflective practice sessions due to high patient caseloads. Staff on wards for people with a learning disability described receiving reflective practice sessions, but this was no longer routine practice across the hospital.

- Staff reported patients were offered a debrief following serious incidents and we saw staff used a proforma for completing these. However, a patient on Cheviot ward described a traumatic incident involving restraint by staff when accessing physical healthcare outside of the hospital and staff did not offer him a debrief.

- Between December 2018 and June 2019 there were 532 near misses reported at the hospital. Of these the most common three were threats, abuse or violence to staff (164) or between patients (43) and incidents of disruption to service due to low staffing which related to staff locking day rooms, cancelling patient activities and fresh air breaks and doing observations without break (43). A near miss is an unplanned event that did not result in injury, illness, or damage. Only a fortunate break in the chain of events prevented an injury, fatality or damage.

- Staff received feedback from investigation of incidents, both internal and external to the service. However, staff told us that it took a long time to filter through to them and that they did not get feedback or a sense of change

when they reported short staffing as an incident. Speech and language therapists we spoke with told us they did not receive feedback from incident reports regarding cancelled therapy sessions or when they were moved to cover work on the wards.

- The hospital distributed a learning lessons flier. The June 2019 edition included information from the physical health matron about physical health monitoring in seclusion. The July 2019 edition discussed monitoring for constipation in patient who was prescribed clozapine.

- The trust-wide bulletin described key lessons learned from serious incidents and complaints from across the trust and directed staff to the relevant policies and procedures for further information as well as a key point of contact within the hospital. This included this example:

- A Rampton Hospital patient complained that staff numbers had reduced, and this meant patients could not always leave their room and access drinks and locker items in a timely manner. The hospital investigated this and found patients often did not to get out of segregation because of staffing levels. The investigation made recommendations for staff to review and discuss this in monthly community meeting with patients. It recommended staff complete incident reports when staffing issues affect patients having time out of segregation. It also recommended weekly segregation reviews. This is to ensure staff record activity time and the multidisciplinary team know if patients are not getting out of their rooms. However, our inspection found the hospital had not embedded the later actions across the hospital following lessons learnt.

- Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation when things went wrong. Senior managers discussed whether duty of candour applied as soon as incidents they were aware of incidents. Investigation reports identified lessons learnt. Staff undertook reflective practice and recorded it in some instances.

Are services effective?

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

Our rating of effective went down. We rated it as requires improvement because:

Assessment of needs and planning of care

- We looked at 66 sets of care and treatment records across the hospital. All records showed staff completed a comprehensive assessment of the patient's mental and physical health on admission and used these assessments to develop comprehensive care plans that demonstrated patient involvement. Staff teams held a multidisciplinary team meeting one week after each patient's admission to review and update the patient's care plans and risk assessment. Following this, we saw evidence that staff updated care plans regularly to include each patient's presenting needs.
- We saw evidence of multidisciplinary team involvement in assessing and providing ongoing support to patients. This included several examples of effective multidisciplinary team working to support patients in a holistic manner.
- Overall, patients' care plans reflected their individual needs and treatment goals. Staff developed care plans that were detailed, holistic, person-centred and matched the needs of patients. We saw good examples of comprehensive care plans on the wards for people with a learning disability and saw staff had developed detailed communication and positive behaviour support plan. However, on Burne ward we reviewed a patient's care records and noted little evidence of staff supporting the patient to set goals as part of their care planning and found that the care plans lacked detail. For example, with regards to their care plan around relationships with others.
- 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. However, on Blake ward we noted delays in staff offering patients a copy of their care plans.

Best practice in treatment and care

- Staff still did not always use the National Early Warning Score system to monitor patients' physical observations and identify when they needed to take further action properly. The National Early Warning Score system aims to standardise the assessment and response to acute

illness. We reviewed the National Early Warning Score charts of 42 patients across the hospital. We found errors or inaccuracies in 31% of these score charts. Errors included staff not scoring or inaccurately scoring the charts at the bottom of the sheet to indicate the patient's total National Early Warning Score, staff not escalating an elevated score in line with national guidelines, staff not repeating the patient's physical observations in line with national guidelines and occasions where the National Early Warning Score chart scores did not match the documented scores input into the patient's electronic notes. We noted issues with this in our last inspection and issued a requirement notice to ensure the hospital calculated and entered all National Early Warning Scores into the electronic records system.
- Carers were concerned about obesity management. Two carers we spoke with raised concerns about obesity and felt the hospital needed to be more proactive in managing this. Another carer told us they were aware the hospital was working with patients to promote weight loss and healthy lifestyle, but that this was an ongoing issue. One carer told us they felt there was not enough healthy food available to patients. However, another carer gave positive feedback about the way in which staff supported their relative to access healthy food and manage their weight.
- Patients reported limited of access to the gym. This was because staff required training to support patients in the gym. Although the Trust report that this training has never been cancelled, staff and patients we spoke with told us the hospital frequently cancelled this training.
- Staff provided a range of care and treatment interventions suitable for the patient group. In the 66 records we reviewed we saw evidence that interventions were those recommended by National Institute for Health and Care Excellence. These included medication, psychological therapies, training and work opportunities intended to help patients acquire living skills. For example, staff offered a comprehensive range of one to one psychological therapies, including schema therapy, dialectical behaviour therapy and groups such as violence reduction and mental health awareness groups. We saw evidence that staff tailored each patient's therapeutic timetable to suit their individual care and treatment needs. However, staff reported that short staffing was affecting this.

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- Staff used evidence-based therapeutic interventions and described examples where they had completed comprehensive reviews of the current evidence base to inform their proposals for a new self-esteem group on the women's wards.
- The hospital was committed to implementing trauma-informed care. This means treating a whole person, considering past trauma and the resulting coping mechanisms when attempting to understand behaviours and treat the patient. The hospital had stated that it would train all ward-based nursing and therapy and education department staff in trauma-informed care by the end of 2019. At the time of our inspection 296 staff had completed the training and a further 407 staff had booked on the course.
- Patients reported good access to good physical healthcare facilities, including access to specialists when needed. The physical healthcare centre operated Monday to Friday. The hospital had recruited additional staff to introduce a seven-day service to relieve medical staff of some work at weekends. The physical health centre offered a range of services at Rampton Hospital. 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.
- 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, staff told us it was unclear who led on patients' physical healthcare. They reported communication issues resulting from unclear boundaries between the role of ward doctors and physical healthcare centre staff contributed to this. For example, staff asked GPs to look at low risk physical health issues that registered general nurses could have managed. Psychiatrists were concerned that physical healthcare took too much of their time.
- Physical healthcare was discussed in ward rounds for example on Burne ward we saw evidence of that staff gave careful consideration to patients' physical health needs. We saw staff understood the needs and preferences of patients. On Ruby ward, staff were piloting the use of a physical healthcare handover book.
- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. We saw three records in which had patients displayed dramatic weight loss. Records showed that dieticians had reviewed and planned interventions for these patients. However, ward staff had not developed care plans from the advice of dieticians to guide care delivery.
- Staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. The physical healthcare centre supported patients to access health screening. Patients on the women's wards grew their own fruit and vegetables as part of a healthy eating scheme. The hospital had a cycle track and outdoor fitness equipment for patients with grounds access. We did not see patients accessing these during the inspection.
- Staff used recognised rating scales to assess and record severity and outcomes for example, Health of the Nation Outcome Scales. Speech and language therapists used therapy outcome measures, which they were reviewing to allow standardised use across the hospital.
- Staff used technology effectively to support patients. For example, an electronic system prompted staff to access blood test results. They also had online access to self-help tools. The computer system prompted physical healthcare centre staff to when patients' annual health screening reviews were due. GPs could review blood test results either on site or remotely. The on-call duty doctors were informed when blood results arrived out of hours.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. The hospital shared examples of lessons learnt from clinical audits with staff. For example, audits of physical healthcare monitoring of patients in seclusion highlighted issues with National Early Warning Scores recording. The hospital provided clear guidance for staff on how to improve consistency of practice in this area through lessons learned. Audits of ward round procedure also took place in 2019.
- The hospital was proactive in benchmarking restrictive practice and staffing with the other high secure hospitals.

Skilled staff to deliver care

- Staff at the hospital included or had access to the full range of specialists required to meet the needs of patients. Staff included doctors, nurses, occupational therapists, clinical psychologists, social workers,

Are services effective?

Requires improvement ●

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pharmacists, clinical nurse specialists, speech and language therapists, dieticians and peer support workers. The hospital also had an art therapist and music therapist. However, staffing shortages and deployment of staff to maintain safe staffing as well as high caseloads, impacted on the level of responsiveness and effectiveness of staff. We saw the teams worked well together to deliver effective care and treatment.

- One serious incident reviewed concerned a patient who did not receive appropriate nutrition or hydration for 17 hours. The patient required gastronomy tube feeding. However, the incident investigation identified that no suitably trained staff had been available to escort the patient out of grounds on this day. The trust reported that training had been subsequently provided to ensure there were qualified staff on each shift.

- Staff expressed concerns about the ratio of qualified to unqualified staff and high numbers of inexperienced staff. This impacted on the experience of a team to manage patients with complex needs. Staff said this resulted in them feeling unsafe.

- Most staff told us managers provided staff with supervision. Supervision meetings discuss case management, reflect on practice, and provide support and professional development. The hospital's clinical supervision compliance was 74%. However, some staff we spoke with told us the access to and the quality of clinical supervision was not always good. Staff kept their own clinical supervision records, so we could not check the quality. For example, one staff member told us they had not received supervision in three years, another staff member told us they had not had supervision since moving to a new ward three months ago.

- 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 four management supervision files and saw staff had briefly recorded the areas discussed. This included work life balance. Staff also reported access to monthly group supervision on the wards.

- At Rampton Hospital, 25% of qualified nurses had training in learning disabilities. In the learning disability service 78% of registered nursing staff were registered learning disability nurses. The Trust reported that the data of 78% included Grampian ward (deaf service) as Grampian sat within the learning disability care stream,

however it was provided to patients with a mental health concern. When these staff were excluded the number of registered nurses who are learning disability registered in the learning disability service was 97%.

- Managers provided new staff with appropriate induction and used the care certificate standards as the benchmark for healthcare assistants.

- Managers tried to ensure staff had access to regular team meetings. Staff we spoke with acknowledged the support of senior managers to try to improve staff access to team meetings and reflective space sessions. However, staff told us this remained a significant challenge. For example, staff in the personality disorder directorate had recently developed monthly team leader meetings but said staffing needs often interrupted these meetings. Speech and language therapists reported cancellations to their monthly team meetings two thirds of the time due to staff being deployed to wards.

- Most staff had access to appraisals from managers. The percentage of staff that had had an appraisal between June 2018 and June 2019 was 75%.

- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles. There was good provision of training available. For example, speech and language therapists had access to dysphagia training. All staff on wards for people with a learning disability had done autism awareness training. The hospital funded one staff member to complete a Masters course in Autism. However, psychologists told us they did not have time to do training or research. Staff we spoke with told us the hospital pulled them off training courses due to staff shortages.

- Managers dealt with poor staff performance promptly and effectively. However, one staff member we spoke with told us they felt unsupported by their performance management, undermined by colleagues and that they were fearful of reprisals.

- The hospital recruited volunteers and trained and supported them for the roles they undertook. For example, volunteer befrienders were matched a patient who had applied for a volunteer visitor. The hospital ensured befrienders had adequate training and not left alone with patients. Feedback provided by ward

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managers, patients and befrienders about the befriending service was positive. The hospital recruited staff to escort visitors and contractors around the hospital site.

Multidisciplinary and interagency team work

- Staff shared information about patients at effective handover meetings within the ward team. We saw examples of detailed clinical handovers between staff when the hospital moved staff from one ward to another. However, in our focus groups and individual interviews during our inspection, staff 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. Staff raised concerns about not always knowing the current risks of each patient in detail and how this led to increased risks of patients gaining access to restricted items.
- Staff held regular and effective multidisciplinary meetings. During our inspection we saw evidence that when members of the multidisciplinary team were unable to attend ward rounds, they provided comprehensive feedback in advance of the meeting. This outlined how they had supported the patient during the review period. We attended a ward round on Bonnard ward and saw that multidisciplinary team staff had thoughtful and patient-centred discussions which supported patient progress.
- Care programme approach meetings were held regularly and were well managed. We observed a care programme approach meeting on Emerald ward. This was positive, person-centred and staff had a good understanding of what the individual patient's wishes were. We saw staff were professional, caring and understanding of the patient.
- Since our last inspection, the hospital has changed the way it did care programme approach meetings. The hospital no longer held care programme approach meetings as part of ward round. We found this change meant there was now more time for reflective practice alongside the patient reviews. External agencies attended the meetings regularly.
- The hospital model used to treat patients was not always clear to staff. Psychology staff told us they felt the hospital has worked to a medicalised model, which focussed on medication. However, we did not see

evidence of this during our inspection. We saw evidence that psychiatrists took a psychological approach to care and treatment in the ward rounds on Bonnard and Burne wards.

- Members of the multidisciplinary team we spoke with told us nursing staff gave them a handover regarding patients' risks when they were covering the wards during periods of short staffing. Ward teams had effective working relationships, including good handovers with other relevant teams within the organisation.
- NHS England commissioners carried out care and treatment reviews and the hospital received positive feedback about current care and treatment timelines.
- The ward teams had effective working relationships with teams outside the organisation.
- Rampton Hospital had effective working relationships with the two other high secure hospitals, benchmarked performance data and discussed staffing. The hospital had adopted the clinical harnessing opportunities, protective enhancement model (Hope model) from one of the high secure hospitals to reduce long-term segregation.
- The dedicated GPs employed in the physical health centre were integrated into the hospital.

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

- In our previous inspection we found seclusion and long-term segregation reviews were not undertaken in accordance with the Mental Health Act Code of Practice. Our Mental Health Act review of seclusion in June 2019 found the hospital had further improvements to make. In two of the records we reviewed on Cheviot and Ruby wards, we found patients' first medical review did not take place within the first hour of seclusion. On Cheviot ward, staff had written in one patient's records "unable to do nursing review due to being on other observations". One record we saw on Ruby ward did not include an independent review of seclusion. One record on Cheviot ward and one on Ruby ward, that two nurses did not consistently complete nursing reviews. For one patient on Ruby ward we could not find evidence that staff had completed a medical review. One record we looked at on Adwick ward was missing four-hour medical checks. On Adwick and Bonnard wards, staff had not completed seclusion care plans for two patients.

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- Reviews could not be undertaken in seclusion rooms due to short staffing. For example, on Erskine ward on 29 June 2019, staff did not enter the seclusion room due to short staffing levels at 10:45 and 12:45 and undertook reviews of a patient in seclusion from outside of the seclusion room. Post inspection the trust reported the patient was released from seclusion at 13.00 and that there were sufficient staff on duty in this case. The Mental Health Act Code of Practice states staff can complete seclusion reviews without entering the room if the risk to staff deems this necessary however, it is a concern that staffing resources were the reason not to enter the room. Best practice is to enter the seclusion room to enable the clinicians to conduct a thorough assessment of the patient's physical and mental state where possible.

- The hospital had clear processes in place to monitor patients' mail, in line with section 134 of the Mental Health Act. Staff displayed information about and explained section 134 mail monitoring to patients. Only patients in high secure hospitals can have their mail monitored. However, there were occasions when staff were unable to review patients' mail within the specified seven-day timeframe and this caused delays in patients accessing their mail. One patient on Grampian ward and one patient on Eden ward raised concerns about delays in accessing their mail due to the mail monitoring system. We saw examples of staff supporting patients to understand why staff monitored their phone calls.

- The provider had trained 80% of staff in the Mental Health Act. 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.

- Patients had easy access to information about independent mental health advocacy. We saw evidence that advocates support patients on the wards, including during ward rounds and attended community meetings when possible.

- 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. This also included information given and displayed about section 134 mail monitoring.

- Staff ensured patients were able to take section 17 leave (permission for patients to leave hospital) when doctors granted this, an 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 stored copies of patients' detention papers and associated records (for example, section 17 leave forms) correctly on patient electronic notes so they were available to all staff that needed access to them. Hard copies of section 17 leave forms were available.

- Section 117 aftercare planning meetings took place on the wards to discuss discharge plans. Care plans referred to the identified section 117 aftercare services needed.

- 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

- Although the provider had trained 78% of staff in the Mental Capacity Act, staff did not consistently demonstrate a good understanding of the Mental Capacity Act, in particular the five statutory principles.

- Staff did not regularly consider capacity for decision specific issues. We saw that staff had not completed mental capacity assessments on whether patients had capacity to refuse medication and staff incorrectly recorded their decision on a section 62 form. Staff across the hospital did not 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 especially on the wards for people with a learning disability.

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- However, we saw a good example of a mental capacity assessment in the women's directorate around diabetes management. We saw examples of how staff made decisions in a patient's best interests such as when using mechanical restraint.

- 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. The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Are services caring?

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

Requires improvement ●

Our findings

Our rating of caring went down. We rated it as requires improvement because:

Kindness, privacy, dignity, respect, compassion and support

- Patients and staff told us that a minority of staff had used or condoned the use of racist and other inappropriate language towards patients. Some staff and patients raised concerns about staff attitudes and language towards patients expressed in negative "banter" with or around patients. One patient on Erskine ward described a coercive atmosphere where staff asserted power over patients. A patient we spoke with in the women's service told us staff provoked patients. This culture is of serious concern in a closed clinical environment.

- One carer we spoke with told us they felt the hospital needed to do more to engage carers from black and minority ethnic backgrounds as they were under represented at carers days. They also raised concerns that staff lacked basic awareness of the patient's cultural background.

- We observed most staff to be responsive to patients' needs. However, on Burne ward we noted two occasions where patients politely requested to use the phone and staff did not respond to the patients' needs for over twenty minutes, despite telling the patient they would support them in five minutes.

- Overall, staff attitudes and behaviours when interacting with patients showed they were discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it.

- During our inspection, we observed positive interactions between staff and patients. Staff were non-judgmental towards patients. There was a calm atmosphere on wards we visited.

- We observed staff actively involved in a family visit, listening to and engaging with patients. Seven of the eight carers we spoke with told us staff were friendly, approachable and supportive when they came to visit the hospital.

- Staff praised patients for positive progress and their individual achievements. It was clear that staff supported the patients in their treatment pathway to achieve realistic goals and genuinely wanted the patients to progress.

- Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, on Aintree ward only staff members familiar with a patient escorted him to the dentist to manage his anxiety.

- Staff understood the individual needs of patients, including their personal, social and religious needs. Culturally appropriate meals were available. Staff we spoke with and patient records we looked at showed care was person-centred and staff had detailed knowledge of the patient group and how best to support patients in their care and treatment. For example, staff were aware of which patients did not like warmer weather and staff were aware of difficult dates and anniversaries that may trigger incidents with patients.

- Staff maintained the confidentiality of information about patients. In 2018, the hospital's Patient-Led Assessment of the Care Environment survey score for privacy, dignity and wellbeing was 94.22%. We saw examples of this during our inspection including staff closing the nursing office door before discussing individual patients' care plan.

- During our Mental Health Act review visit to Emerald in March 2019, we raised concerns about patient privacy in relation to a screen showing closed circuit television images that was displayed in a communal area of the ward to help staff observe patients. During this inspection, we reviewed this and saw that staff only switched these screens on at night time, when all patients on this ward were subject to night time confinement or nursed under specific segregation plans.

Involvement in care

Involvement of patients

- Staff used the admissions process to inform and orient patients to the ward and to the service. We saw that staff invited new patients from other wards within the hospital to the ward community meeting prior to their admission to that ward.

- Staff involved patients in care planning and risk assessment. We saw staff supported patients to

Are services caring?

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

complete a request form prior to their ward round review meeting to aid discussion. During Burne ward round, we saw that staff reviewed a patient's mental health symptoms and checked that the patient was aware of their medication dose and possible side effects. The patient demonstrated a good understanding of their care and treatment plans. We observed a ward round on Aintree ward and saw that staff sought patients' views engaged patients in discussions.

- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff asked patients for their views about their current care and treatment plans. For example, during ward round on Burne ward, we saw that staff fully involved a patient who attended the discussions. It was clear that staff had spent time with the patient before the meeting to discuss some complex information. Staff summarised the information at the end of the meeting to check the patient's understanding.
- When appropriate, staff involved patients in decisions about the service. For example, in the recruitment of staff. Patients have a separate panel with job candidates and there was positive feedback about this from patients.
- Staff enabled patients to give feedback on the service they received. Wards held regular community meetings that were well-advertised on patient noticeboards, recorded and available in easy-read format where required. Where patients raised feedback in community meetings, staff addressed this feedback. For example, on Kempton ward patients raised concerns that meal times were particularly noisy on the wards and staff addressed this by making mealtimes more structured to make it quieter.
- In the care opinion survey patients gave compliments to the therapies and education staff and the Diamond Resource Centre where activities took place. Five patients gave compliments about the Westfield outdoor gym space. The patient council had good attendance from each of the directorates across the hospital. We observed a patient council meeting and reviewed minutes of meetings in which there was consistent feedback about staff shortages and the impact on activities and fresh air.

- The second annual Health and Fitness Awards ceremony took place at Rampton Hospital in February 2019, celebrating the achievements of patients over the year. There were awards for swimming as well as the monthly challenges throughout the year, with winners receiving certificates and T-shirts. Patients gave feedback on the fitness department via a questionnaire and 99% rated it as fantastic or good.
- Staff enabled patients to make advance decisions. An advance decision is a decision you can make now to refuse a specific type of treatment at some time in the future. Whilst not explicitly recorded as advance decisions, staff did describe advance planning with patients to ensure they understood their care preferences if they became distressed.
- Staff ensured patients could access advocacy which was provided independently on site.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. The social work team took the lead on engaging with families and carers. The social work team updated families on changes within the hospital that may impact them. For example, the social worker on Aintree ward had recorded they had discussed the change in the policy around bringing photographs on the wards with a patient's family member. However, two carers gave examples of when the hospital had changed its policy on what carers could bring in to the hospital when they visited without explaining why this change had happened. When they raised this with senior staff they did not feel they received an adequate explanation.
- One carer told us they witnessed an incident at the hospital when they came to visit. Staff contacted them afterwards to offer support and a debrief.
- Families and carers to give positive feedback on the service they received. Carers days provided an opportunity for feedback and discussion. The hospital provided a carers hotel and supported carers with travel costs to facilitate visits to their relative. Carers gave positive feedback on the carers days and the wellbeing event held for carers in June 2019.
- Each ward had a carer's champion who supported carers with access to information about their family member.
- Staff provided carers with information about how to access a carer's assessment through the local authority.

Are services caring?

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Carers visited from all over England and the hospital provided accommodation support. Carers who stayed overnight at the visitor centre facility gave positive feedback and thanked the family support team.

Are services responsive to people's needs?

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

Our findings

Our rating of responsive stayed the same. We rated it as requires improvement because:

Access and discharge

- The average length of stay was 6.82 years, this was higher than the other two high secure hospitals. The specialist commissioners informed us that they were undertaking a review of the 78 patients who had been at the hospital for over ten years. We saw that there were patients who had been there for up to 29 years.
- NHS England specialist commissioners commissioned the local, regional and national services at Rampton Hospital. Patients came via the criminal justice system as well as from low or medium secure units.

Bed management

- In July 2019, bed occupancy was higher than usual at 90%. This was because of the closure of a ward in the services for patient with personality disorder in March 2019. The Royal College of Psychiatrists recommend 85% bed occupancy.
- There was always a bed available when patients returned from leave. The hospital did not move patients between wards to support new admissions. When the hospital moved or discharged patients, this happened at an appropriate time of day. A bed was always available in a psychiatric intensive care unit if a patient required more intensive care within Rampton Hospital.

Discharge and transfers of care

- There were 18 delayed discharges for non-clinical reasons during 2018/2019 Quarter 4. Nine of which were in the personality disorder directorate, five in the women's services and three in the men's mental health and the learning disability directorates and from the deaf service. The hospital reported an increase in delays since October 2018 following the adoption of the definition that a delayed discharge was from three months following the date identified by the clinical team that a patient was ready to move to lesser security. The reasons for delays were broadly due to a national shortage of beds in medium secure units, clinical teams identifying alternative units, waiting for gatekeeping assessments, agreeing funding agreements and awaiting Ministry of Justice applications/permissions.

- The hospital reported that there were lengthy delays in returning patients to prison which had a detrimental impact on the patient and could impact on delaying other admissions to the hospital.
- During our focus groups staff reported concerns about progression within the mental health and personality disorder care pathways, and that patients were waiting too long for beds on treatment wards. For example, two patients were ready to move from long term segregation to treatment beds, but the wards were full.
- Some patients said they were not always clear what they had to do to move on. One patient on Quantock ward reported having lost confidence in moving on and said they felt neglected and forgotten about. They said they regularly raised this in ward rounds but had not received any helpful feedback.
- We saw examples of effective working relationships and comprehensive clinical handovers with other providers as part of patients' admission and discharge planning. This included ongoing communication with previous or new care providers to support patients in their care pathway.
- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. We saw staff support for gatekeeping assessments to support patients to move to a service with a lower level of security as part of their care and treatment pathway. The hospital did not move patients on before they were ready. Records showed that staff supported patients to set goals for their care and treatment to support their progress.
- The hospital was part of the East Midlands New Care Model for secure services, which aimed to improve the way forensic mental health services provide care to patients across the region. Senior managers hoped that working in collaboration with the other providers in this model would support the reduction in delayed discharges by enabling smoother transitions between services for patients. However medical consultants at Rampton Hospital expressed concerns that they had not been adequately engaged and consulted with about the new model.
- Staff supported patients during referrals and transfers between services for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. Staff supported patients to attend court hearings. The hospital also used video links to courts.

Are services responsive to people's needs?

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Facilities that promote comfort, dignity and privacy

- Staff and patients told us there were issues with the wards becoming too warm. The hospital had made a capital bid for the upgrade of current areas that have air conditioning. As a lesson learned after recent hot weather the hospital identified that the current fans were not sufficient to support cooling of the wards and therapy areas so 84 large industrial fans had been ordered for the wards and therapies and education department patient care areas and were awaiting delivery. The hospital had encouraged wards to order frozen drinks/ice pops for patients and staff.

- Several patients told us they were unhappy with the prices in the hospital shop and this was discussed in patient community meetings. We raised this as an issue during our last inspection. The hospital provided evidence that the issue had been discussed at various meetings and the hospital had developed an additional provisions working group to review the cost structures for patients. This group consulted patients and carers and gave monthly feedback at patient council meetings.

- Therapies and education department cancellations often included horticulture and day centre groups. We saw an example of a weekly cancellation sheet seen on Quantock ward. Between 1 and 5 July 2019, the therapies and education department had cancelled 18 planned activities across the hospital site for that week.

- There were ongoing issues with recording of activity. We noted on Ruby, Emerald, Burne and Cotswold wards cancellation sheets were not completed between 1 and 2 July 2019 and there was limited descriptions of activities. For example, it said "on ward", "off ward". Staff said they were not logging patient activity accurately due to time constraints. However, the trust had reviewed the way it captured activity data and had introduced a paper form for staff to complete. Completed forms were uploaded onto the electronic activity monitoring system. Monthly audits were undertaken which determined the level of compliance with completion. The trust had reported an increase in activity levels in each area.

- Patients on wards across the hospital told us when the ward was short staffed, there were delays in serving food at meal times which meant staff were sometimes serving cold food. Patients told us this was particularly an issue on Eden ward.

- Patients could not consistently make hot drinks and snacks 24 hours a day, seven days a week. Staff and patients told us that staff shut dining areas due to staffing pressures, which limited access to hot drinks.

- The hospital was developing hand held devices to facilitate online shopping for patients. They were planning this in line with the High Secure Directions.

- The hospital aligned occupational therapists, speech and language therapists, arts therapists, day unit technical instructors and therapy assistants to specific care streams. All other technical instructors in vocational services, health and fitness and education staff worked across all the care streams. The education service recently changed their way of working to provide their services from the day centres in the care streams rather than in a central location.

- Psychology staff reported some psychology sessions were not able to go ahead as planned because nursing staff were not available to accompany them, for example on Brecon and Cheviot wards.

- Patients in long-term segregation on women's wards reported issues with talking through the hatch as it was difficult to hear staff and have a two-way conversation.

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Patients could personalise their bedrooms based on risk assessments. We observed parts of the communal areas were personalised by patients where risk allowed.

- Bedroom doors had curtains in the mental health and personality disorder services, which could have compromised patients' privacy and dignity. During the last inspection we commented that dignity could be compromised because in some wards, the external curtains over the observation windows and bathroom could be pulled back by any patient walking down the corridor. On Alford ward we saw that the curtains were dirty. The trust had considered this concern but did not feel there had been an incident which compromised patient dignity in this way. The feedback the trust sought from patients was that they liked the curtains, as the integral blinds make a noise at night time and so the curtains have therefore remained.

- Patients had somewhere secure to store their possessions. Staff and patients reported improved processes around this since centralised property management came into force. Patients had their own lockers with keys (this was risk assessed) to store their personal possessions. Staff locked other restricted items

Are services responsive to people's needs?

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

away and accessed them only with staff supervision, for example glass containers, aftershaves and razors. Staff completed risk assessments to decide whether patients could have access to a key for their bedroom door for during the day.

- Staff and patients had access to the full range of rooms and equipment to support treatment and care such as a clinic room to examine the patients, activity and therapy rooms. Many wards such as Aintree ward had a low-stimulation room with sensory equipment including soft chairs and bean bags.
- There were quiet areas on the ward and a room where patients could meet visitors.
- There were phones for patients to use on all the wards. These were in communal areas but had a hood to maintain privacy. However, on Topaz ward the patient phone was in the corridor directly opposite the patient lounge. If a patient requested a private call the procedure was to restrict access to the corridor for fellow patients on the ward and this led to restrictions on other patients.
- Patients had access to outside space. The hospital had a range of outdoor facilities such as cycle tracks, outdoor gyms, football pitches. We did not see patients using these during inspection, however, we did see some patients going out for walks and jogging. First floor wards had access to ward gardens. Eden ward garden area was overgrown however, this was because staff had removed garden tools in response to risk.
- The food was of good quality. In June 2018 the Patient-Led Assessment of the Care Environment score for food was 89.6%. We observed a meal time on Aintree ward. We saw patients had a range of different meal options and patients told us they chose what they wanted from a menu.

Patients' engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities.
- Staff supported patients to enter the Koestler Trust awards, a national charity that awards, exhibits and sells artworks by secure hospital patients and prisoners. A patient entered their sculpture from the "sense of community programme" into the National Service User Awards. Cotswold ward had planned a patient community day in July 2019. NHS England commission the "sense of community programme" to try and improve quality and innovation.

- Staff supported patients to maintain contact with their families and carers. We saw examples where staff supported patients to have visits from their family members on the ward. This enabled families to see where the patient was living. Rampton Hospital implemented this good practice, which not all national forensic services did.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Patients provided positive feedback on the befriending service provided. A patient told us how the hospital helped them to support a charity throughout the year as the patient wanted to give something back to the community.

Meeting the needs of all people who use the service``

- Grampian ward provided a national service for deaf patients. Out of 30 staff on Grampian, 28 had some form of British Sign Language qualification. Most staff were trained to level one or two British Sign Language which enables basic communication to occur. A total of seven nursing and multidisciplinary team held a level 3 British Sign Language qualification and two were awaiting training. Level 3 allowed staff to understand and use varied sign language in a range of work and social situations. One support worker had completed a level 6 certificate in British Sign Language and one psychologist was awaiting training.
- Patients we spoke with on Grampian ward reported a lack of British Sign Language trained staff at night. They told us this made them feel unsafe and led to limited interaction between patients and staff. Patients on Grampian ward told us that when risk assessment determined staff use handcuffs to escort them to external appointments, this made it difficult for them to use sign language.
- During our inspection there was a deaf patient on a ward which was not part of the deaf service. Staff on this ward had not received sufficient training in British Sign Language. The patient told us this left them feeling lonely and misunderstood. At the time of our inspection the hospital was in the process of recruiting two more support workers who knew British Sign Language. Staff from Grampian ward attended the other ward's staff away day to provide training for staff around how to support deaf patients. Members of the multidisciplinary team sought advice regarding this patient's pathway.

Are services responsive to people's needs?

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

- At the time of our inspection, Rampton Hospital provided their own interpreters to support patients with appointments to acute hospitals. This impacted on staffing on the wards. Staff told us this was because there had been several occasions where patients had attended appointments and the acute hospital had been unable to provide an interpreter.
- Staff ensured that patients had access to appropriate spiritual support. However, the hospital had occasionally cancelled Friday prayers for Muslim patients due to staffing pressures. On Grampian ward patients reported issues with access to interpreters to support their religious or spiritual needs.
- The service made adjustments for disabled patients by ensuring disabled people's access to premises and by meeting patients' specific communication needs. For example, on Ruby ward a patient had a mobility aid and the right chair for their needs. Eden ward had disabled access throughout the ward. Topaz ward had wide doorways and disabled shower access.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. We saw that information for carers was available, recovery booklets, mental health and physical health problems leaflets and information on advocacy services. Aintree ward had information about "what is autism" displayed.
- Staff supported patients to orient themselves to what was taking place on the ward each day. All wards had a noticeboard showing patients which staff members were on shift, who was their named nurse, the names of any visitors to the ward and activities for the day. We noted on Emerald ward this was not up to date on the day of our inspection.
- On Topaz ward staff provided patients with an information pack upon admission. Staff assisted patients to go through the pack and it was available in easy read format.
- The hospital displayed information on how to complain to the Care Quality Commission Mental Health Act team. The hospital did not display information about the NHS England complaints process.
- The hospital had information available about the Rainbow Club for lesbian, gay, bisexual or transgender patients. We saw evidence that staff on one of the wards supported a patient to access a gender clinic. Staff had

developed personalised and detailed care plans around this. However, one patient reported feeling discriminated against and that staff did not understand their needs.
- The information provided was in a form accessible to the particular patient group (for example, in easy-read format on wards for people with a learning disability). Staff used social stories to support patients to understand their care and treatment. On Burne ward we saw that the Mental Health Act Code of Practice was available in easy read format.
- Patients with a learning disability had access to their positive behaviour support plans in easy read format with pictures. On Cheltenham ward we saw that staff offered patients emotions cards to keep in their pocket to present to staff to communicate how they are feeling.
- Staff made information leaflets available in languages spoken by patients.
- Managers ensured that staff and patients had easy access to interpreters. Staff reported they were able to access support from interpreters as and when required through the trust's intranet page. The hospital had arranged a Polish interpreter to support a patient to understand complex clinical information. They were looking into having a Polish chaplain and looking for a Polish speaking psychologist to support a patient of this nationality. Staff also had access to interpreters for family visits.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Listening to and learning from concerns and complaints

- Between April 2018 to March 2019, Rampton Hospital had 287 complaints. In the mental health and personality disorders services there were a total of 187 complaints. In the national services there were a total of 100 complaints. The main themes from patient complaints were focused on the impact of staffing as a result of vacancies and an increased number of staff being needed due to high numbers of observations.
- Between April 2018 to March 2019 in the mental health and personality disorder services, the hospital upheld 28 complaints. In the same period, the hospital upheld seven complaints in the deaf, women's and learning disabilities services.

Are services responsive to people's needs?

Requires improvement ●

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

- Out of eight complaints referred to the ombudsman between June 2018 and June 2019 only one to date has been returned for further local resolution by the hospital.
- All patients knew how to complain or raise concerns apart from on Grampian ward, where patients reported being unsure on how to raise a complaint. When patients complained or raised concerns, they did not receive feedback consistently. Patients reported concerns about the quality of complaints investigations and the complaints process. Some patients did not feel the hospital had given them an adequate explanation or that their complaints had not been taken seriously. One patient said staff had made a promise to him about a situation with a relative which was outside of their control and the outcome of this was negative. This left the patient feeling unhappy as he felt staff had given him false hope. The patient raised a complaint and the chief executive officer responded to this, agreeing that staff were wrong to do this. During our inspection we discussed this with staff and found no evidence of change or lessons learnt.
- Three carers we spoke with were not satisfied with the response they had received from the hospital when they raised queries. However, they did not raise formal complaints. One of the carers we spoke with said they had received a satisfactory response from the trust. One carer told us when their relative's personal belongings went missing on the ward the hospital had reimbursed them.
- Staff protected patients who raised concerns or complaints from discrimination and harassment, although some patients feared raising complaints in case it impacted on them negatively.
- Staff knew how to handle complaints appropriately. For example, on Emerald ward the ward manager met weekly with a patient who had made several complaints in the past so that early redress could occur.
- Some patients on the wards for people with a personality disorder had raised concerns about the suitability of the ward-based activities offered to patients. In response to this, following a ward staff away day, staff set up a working group to involve patients to determine what activities patients would like to engage with.
- Staff received feedback on the outcome of investigations of complaints and acted on the findings, via bulletins and a learning folder located on each of the wards which highlighted themes from incidents and complaints.

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

Our rating of well-led went down. We rated it as inadequate because:

Leadership

Unless otherwise stated, the term 'leader' refers to ward managers, modern matrons and managers at directorate/service line level.

- There was a forensic senior leadership team for the forensic division. Not all senior leaders felt listened to within the senior leadership team. The Rampton Hospital Management committee remit was to make and implement managerial decisions. However, staff, particularly medical staff, told us that they did not know where managerial decisions were made and they did not feel involved in or engaged with in decision making.

- The associate medical director for forensics had a large portfolio which impacted on the time available to devote to the hospital. The trust was reviewing this. The senior executives of the trust were working to establish better engagement and involvement with medical consultants. The trust was currently commissioning the University of Nottingham to support the senior team and medical staff to build trust and confidence. There was recognition it would take time to build up capacity for medical consultants to engage in managerial decision. Medical staff reported that the chief executive was listening to their concerns.

- The need for medical clinical leadership was recognised by the trust. The hospital planned to appoint medical leads for each of the care pathways. The hospital was establishing final details of how to do this safely whilst still recruiting to achieve 1:20 caseloads as a priority. All care streams already had a dedicated matron who would work closely with the medical leads in the future.

- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Hospital site security managers all had clinical experience. They had a detailed overview of the activity across the hospital on a daily basis. They reported an increase in calls from ward staff for support and advice. These managers had ideas about how things could improve in relation to staffing management across the hospital. However, they

did not feel heard and involved in management decision making. There were tensions in the relationship between the hospital security site managers and the clinical leaders such as modern matrons.

- Leaders were visible in the service and approachable for patients and staff at ward level. However, above this, staff reported a lack of visibility of senior managers. Staff felt disconnected from the wider trust.

- The trust had a new chief executive officer who was making some structural changes in the trust, this included advertising a chief operating officer role. This role would create opportunities for some management structural changes at Rampton Hospital. Staff reported they had confidence that the chief executive officer was listening and would act.

- Leadership development opportunities were available, including opportunities for staff below team manager level. Twelve ward managers/senior clinical nursing staff were completing a leadership programme. The trust recognised that clinical leadership needed developing within the hospital. This happened in a variety of ways. For example, a student nurse on Bonnard ward led the ward round meeting as part of their professional development. We saw examples of staff acting up into more senior roles to support their career progression. For example, on Cheltenham ward a staff nurse was acting up as a developmental team leader. Senior managers told us a development programme was available on all wards and was a rolling programme to support staff development. The hospital supported staff with additional training for this role.

- Clinical staff told us they appreciated how hard leaders such as the operations manager and deputy director of forensics worked.

- Between 21 November 2017 and 11 June 2019, 46 staff attended "open conversations" within Rampton Hospital, which the senior leadership team led to discuss their views.

Vision and strategy

- Not all staff knew and understood the provider's vision and values and how they applied in the work of their team. Not all staff knew the aims or philosophy of the hospital or provider. However, staff described improvements in the provider's engagement with

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Inadequate 🔴

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clinical staff about improving the provider's culture and values following our last well-led inspection of the trust. The trust planned to relaunch their vision, values and culture through workshops.

- Not all staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff said there was a lack of communication about what was happening and how the hospital would allocate roles.
- Staff reported they did not feel consulted on or involved in the closure of wards despite evidence to the contrary. We reviewed the meetings the hospital held to consult staff on the closure of Evans ward. We saw evidence that the hospital consulted staff and the minutes of the three consultation meetings demonstrated that staff had the opportunity to contribute to the discussions about the proposed changes. There were ongoing actions throughout the meetings to "speak to psychologists to get their views", but managers appeared not to have actioned this through several meetings.
- Staff told us they were frustrated at the factors that hindered them working to deliver high quality care within the budgets available. Medical staff, psychologists, social workers, occupational therapists and speech and language therapists all expressed concern about their high caseloads.

Culture

- Staff did not feel respected, supported and valued. Staff morale was low across the hospital and staff reported a lack of engagement and involvement in decision making.
- Staff did not feel able to raise concerns without fear of retribution. Some staff we spoke with told us there was a blame culture at Rampton Hospital. Staff said they were fearful of reducing restrictive practices such as observations, long-term segregation and seclusion for fear of something going wrong and being blamed. Staff on one of the women's wards told us there was a bullying and blame culture outside of the ward. They described a top down approach within nurse management, above ward manager level. Staff told us they were aware of occasions where staff had been reprimanded for raising concerns and issues. However, some staff we spoke with gave us examples of when they had openly raised concerns and had been supported by their managers and the trust.

- Staff told us they did not want to speak up when they had concerns due to fear of the hospital moving them to another service within the hospital. Some staff told us the hospital had permanently moved them from working on a ward at short notice. Staff who had whistle blown corroborated this and said the hospital had moved them to another ward because of whistleblowing. They told us about a bullying culture in which there was little or no debriefs or support and they felt that the hospital did not take it seriously when they raised issues.
- Staff knew how to use the whistle-blowing process. However, not all staff we spoke with knew about the role of the speak up guardian. The hospital induction programme included a session on the role of the speak up guardian. The speak up guardian had undertaken awareness sessions at Rampton Hospital and there were two speak up champions. Despite this, staff we spoke with were unaware of the speak up guardian role.
- There were issues with access to quiet rooms on women's service for staff to take breaks. Staff told us there was nowhere on the ward they could go to eat on their break and management berated them if they found staff eating in the office. The trust reported that there were no staff rooms on wards, but rooms were provided off the women's service to support time away from the clinical environment. The trust were clear they would speak with staff about this provision to better support staff.
- Following serious incidents, such as deaths, staff reported ward managers supported them well.
- Despite the challenges, staff felt positive and proud about working for their ward team and providing care and treatment to patients. Between 2017 and 2018 Rampton Hospital was involved in focus groups in relation to "developing our people and culture". At the time of our inspection, the hospital was reviewing this following the appointment of the new trust chief executive and a relaunch of the trust visions, values and behaviours workshops.
- Managers dealt with poor staff performance when needed. At the time of our inspection, Rampton Hospital were investigating 17 disciplinary and grievance cases.
- Staff reported their clinical teams on wards worked well together and where there were difficulties, managers dealt with them appropriately.

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 reported appraisals included conversations about career development. However, staff reported the quality of clinical supervision was not good.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. There were separate staff and patient lesbian, gay, bisexual, transgender groups at the hospital.
- The hospital's staff sickness and absence were similar to the trust's target.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. A range of wellbeing initiatives were advertised and themes of the month promoted. A self-referral confidential counselling service for staff was available.
- The provider recognised staff success within the service, for example, through staff awards. Patients nominated Hambleton ward and the ward won a trust Outstanding Service Contribution and Recognition Scheme award for best clinical team. Emerald ward was nominated for trust Outstanding Service Contribution and Recognition Scheme award for reduction in restrictive practice. The hospital also had team of the month and individual of the month awards. The Coral ward team won the Health Service Journal Patient Safety Team of the Year Award. Coral was awarded this due to its achievements such as reducing restrictive practices, incidents and staff sickness and increases in therapeutic activity, supervision and annual appraisals.

Governance

- Whilst there were good governance systems, our findings from the other key questions demonstrated that governance processes did not operate effectively enough to manage the impact of staff shortages on the patient and staff experience. Staff were not clear about how the governance systems supported them to carry out their roles.
- The hospital did not consistently have effective systems and procedures to ensure that wards were safe. We found that on some wards the kitchen areas were not clean.
- The hospital did not adequately train or supervise all staff in their roles. Patients who were deaf reported there were not enough staff adequately trained in British Sign Language to meet their communication needs. Staff needed further training in physical healthcare so that all clinical staff worked in a culture of physical

healthcare being everyone's business. Staff needed to improve their recording and escalation of National Early Warning Score observations and complete observations in line with the trust's policy.
- The hospital assessed and treated most patients well. However, a minority of staff had used or condoned the use of racist and other inappropriate language towards patients. Some staff and patients raised concerns about staff attitudes towards patients and one patient described a coercive atmosphere where staff asserted power over patients. The trust reported that it took a zero-tolerance approach to patients and staff using racist or other offensive and inappropriate language. The trust investigated allegations and one in 2019 led to the dismissal of a Rampton Hospital staff member who was reported by a colleague to have used racist language.
- Staff generally adhered to the Mental Health Act and Mental Capacity Act, however did not conduct seclusion reviews in accordance with the Mental Health Act Code of Practice.
- Staff did not consistently report incidents or incident reports lacked detail. Staff did not always have time to notify incidents and some staff were fearful in doing so in case there were repercussions.
- There were systems in place to report safeguarding and staff recognised safeguarding issues and reported them. However, the social work team did not think that staff raised safeguarding alerts consistently because staff felt they did not have the evidence. The social work team were working with staff to make improvements.
- The central resource office worked well in reactively coordinating staffing throughout the hospital without software that would assist this. They had to take into account ward staffing numbers, escorts, gender mix, overtime, additional staff for observations, seclusion and long-term segregation. Despite their best efforts, the hospital site was regularly short staffed.
- Shortages of staff affected the staff and patient experience. It resulted in a lot of movement of staff between wards to cover escort duties. Increased demand on staffing took place due to seclusions and long-term segregation. Patients said this affected their access to activities and fresh air. It resulted in restricted patient movement because of confinement to bedrooms or to certain areas in the ward.

Are services well-led?

Inadequate ●

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- Psychologists told us they did not have enough time to complete audits and outcome measures or deliver training to other staff groups.
- The hospital planned discharges well. However, non-clinical external factors had caused delayed discharges.
- There was a clear framework of what staff must discuss at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.
- Staff undertook or participated in local clinical audits. For example, audits of patients' care and treatment plans, infection control audits and National Early Warning Score chart audits. However, we highlighted several errors in the National Early Warning Score charts which staff had not identified in local audits. This suggested the audits were not always sufficient to provide assurance. We saw that staff on Emerald ward had not completed audits on time.
- Staff understood the arrangements for working with other teams, both within the hospital and external, to meet the needs of the patients.
- Board executives undertook quality visits to the hospital.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. The Rampton Hospital risk register identified a range of risks and identified actions to support mitigation. The risk register linked to the forensic risk register and the hospital escalated serious risks to the corporate risk register. This was reviewed by the trust board. We found staff concerns matched those on the risk register.
- The service had plans for emergencies, such adverse weather or a flu outbreak. The trust had an emergency planning policy dated June 2019 which prepared staff for serious incidents, identifying personnel to take the roles of gold and silver command. There was a Forensic Health, Safety, Security and Emergency Preparedness Committee and the trust health, safety security and Emergency Preparedness Resilience & Response management group which had an assurance reporting template. This detailed mitigation about a range of issues for example ligature risk assessments, plans for

lockdown, risk around barricade and hostage taking, violence to staff and between patients. They reviewed serious incidents and looked at trends. However, staff we spoke with were not clear what the threshold was for the hospital raising staffing as a serious incident when levels became dangerously low.

- The hospital had a system in place to consider cost improvements and their impact on quality. Recurrent savings the hospital was making accounted for £3,509,000. The hospital risk register stated that the cost improvement programme between 2016 and 2021 would amount to a 20% reduction of budget over this timeframe, which is significant. Proposed schemes had previously been refused and discarded due to concerns about the impact on quality of care. The reduction in medical caseloads from 1:25 to 1:20 was a response to concerns about the clinical impact of a previous cost improvement that the hospital implemented five years ago.

Information management

- The hospital used a separate electronic primary care system for recording physical healthcare information. There was no access to this system for all clinical staff with a reliance on ward managers and medical staff to link in. Staff had to cut and paste care plans onto the main electronic patient record from this primary care system. Primary healthcare centre staff said that the current primary care electronic system did not give them the functionality needed and wanted the primary care system version which would give them the quality and outcomes framework which would provide better patient data and reports.
- The service used systems to collect data from wards and directorates that did not create a lot of additional work for frontline staff. The hospital was looking at innovative ways to reduce nursing staff time by improving information gathering systems. For example, the hospital reviewed all Treatment Risk Information Management System plans. The hospital either closed these plans down due to being no longer relevant or moved them to the electronic plan system. This enabled all plans to be in one place and encouraged staff to be collaborative and transparent when working with risk with patients. Staff had also revised the ward round feedback template since our last inspection. This was previously a Treatment Risk Information Management System form and multidisciplinary teams found this was

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prescriptive and did not meet the needs of the patient. Three wards across the site piloted the new form. Staff provided positive feedback on the revised form and the hospital planned to roll the form out across the whole site in August 2019.

- Most staff had access to the equipment and information technology needed to do their work, although a few staff said there were not enough computers. The hospital was piloting vital signs technology on Coral ward in the women's service. This could improve the way staff do both physical and mental health observations and improve the experience of patients with a reduction in restrictive practices and intrusive observations. This was being run alongside usual practices to ensure patient safety.

- The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Previous audits of mental health observations evidenced a huge burden on staff with multiple forms to complete and over-complex processes. The hospital was rolling out new observation tablets and improving the experience of staff implementing observations and had implemented this in over half the wards across the hospital.

- The provider ensured staff received annual information governance training and ward managers maintained monthly oversight of information governance systems to address any issues. Information governance systems included confidentiality of patient records.

- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Ward managers had a dashboard they could access to do this. Information was in an accessible format, and was timely, accurate and identified areas for improvement. However, ward managers did not have access to some types of key information on patient groups, such as the average length of stay.

- Staff made notifications to external bodies as needed, including proactively notifying the Care Quality Commission when required.

Engagement

- Staff told us they reported information up to senior managers but not did not receive any feedback in return. For example, staff told us they completed a monthly report on staff moves but did not receive any information back.

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used for example, through the intranet, bulletins and newsletters.

- We saw evidence that the hospital engaged with staff through newsletters, lessons learned bulletins, updates on quality improvement projects, themes from exit interviews, changes in recruitment and retention strategies and in a welcome to new starters.

- We saw copies of the hospital's 'you said, we did' bulletins, which contained several examples of how the provider had implemented changes because of staff feedback. For example, staff raised concerns that training and events needed to be coordinated better because they clashed and at times had to be cancelled. As a result, the provider set up a Rampton Hospital training and development meeting to include an events planner to reduce the likelihood of cancelling training in the future.

- The hospital did a good job of advertising nursing staff council meetings and these were fully operational. The group aimed to be highly influential in relation to organisational developments and improving how the hospital runs as a whole. It also provided a route to feedback to managers. However, staff described challenges in being able to access the nursing staff council due to staffing shortages and managers asking them to stay on the wards instead of attending meetings.

- We saw evidence of senior leaders engaging with groups of staff to provide opportunities for staff to share their views and feedback. Each ward in the hospital had an away day. These enabled managers to respond to staff feedback and make changes. There was a plan to have a senior manager attend each ward's away day to improve engagement and visibility of the senior leadership team. We heard that staff from Erksine ward raised issues about the staff room during their away day and improvements had been made within a week.

- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Patients gave feedback through the patients' council. There were 'you said we did' leaflets on boards for patients and nursing staff. Carers gave feedback on carers days.

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- Patients and carers were involved in decision-making about changes to the service. Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.
- Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch. NHS England held regular meetings and reviews of patients and the trust provided performance management data. Healthwatch undertook patient interviews on the 14 June 2019 for the first time and staff supported them in this. The hospital encouraged staff to engage with Care Quality Commission throughout the monitoring and inspection process. We saw evidence of how the hospital promoted Care Quality Commission's focus groups and the aims of the groups.

Learning, continuous improvement and innovation

- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff had opportunities to participate in research, although psychologists reported their caseloads limited their ability to participate in research.
- Innovations were taking place in the service. For example, the hospital was introducing radically open dialectical behaviour therapy. This is a new evidence-based treatment targeting a spectrum of disorders characterised by excessive self-control.
- The hospital was introducing digital dialectical behaviour therapy. This was to enhance the dialectical behaviour therapy programme and provide patients with interactive resources directly through their personal television to provide in the moment support to practice skills, mindfulness and relaxation techniques.

- Speech and language therapists had developed outreach work with patients in long-term segregation. They had devised "chat boxes" and developed an accessible visual quiz so that staff could play games with patients through the hatch to generate conversation. This was an innovative use of resources to limit the number of staff required, since this could be done without having to open the segregation room door. Staff were encouraged to use these resources on intensive care units to promote interaction.
- Staff used quality improvement methods and knew how to apply them. Quality improvement projects were publicised in the hospital newsletter. For example, staff developed the record keeping quality improvement project during 2018 with a view to developing a well organised ward ethos across all services. The trust quality improvement team supported the project. At the time of our inspection the project was in the initial stages of implementation. The first phase brought a reduction in paperwork and files from ward offices.
- Staff participated in national audits relevant to the service and learned from them, such as care programme approach audits, risk assessment audits in accordance with NHS England commissioning contracts. The hospital participated in the national schizophrenia audit.
- Wards participated in the Royal College of Psychiatrists Quality Network Forensic Mental Health Service accreditation as peer reviewers and learned from them. The Royal College of Psychiatrists Community of Communities accredits the hospital's therapeutic community in the learning disability care stream.

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 hospital must ensure staff feel confident and are competent to implement physical healthcare plans effectively. The hospital must ensure National Early Warning Scores are completed accurately and acted upon in line with national guidelines. The hospital must ensure that all medication is signed for and medicines are not stored or used after their expiry date. The hospital must ensure that all staff adhere to the trust's observation policy when conducting and recording observations.

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 hospital must ensure recording of seclusion and long-term segregation reviews are undertaken in accordance with the Mental Health Act Code of Practice. 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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirement notices

Surgical procedures	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.
Treatment of disease, disorder or injury	The hospital must ensure staff have sufficient time and are supported to report incidents accurately.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Diagnostic and screening procedures	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.
Surgical procedures	
Treatment of disease, disorder or injury	