Ellingham Hospital

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	
Are services caring?	Inadequate
Are services responsive?	
Are services well-led?	Inadequate

Overall summary

The Care Quality Commission carried out an urgent, focussed and unannounced inspection of the child and adolescent inpatient wards at Ellingham Hospital on 4,5 and 10 September 2019.

The Care Quality Commission has a duty under Section 3 of the HSCA to consider the immediate safety and welfare of the young people at the hospital.

We found significant and immediate concerns that required immediate action. We worked closely with the Norfolk and Young People Clinical Commissioning Group, Norfolk Local Authority, NHS England and the Priory Group senior management team to ensure that immediate concerns for the health and wellbeing of the young people were acted on. We began enforcement proceedings against Ellingham Hospital to require closure of both child and adolescent mental health wards.

Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.

Summary of findings

We rated the child and adolescent mental health wards at Ellingham Hospital as inadequate because:

- Senior managers failed to provide a consistent and stable leadership team, including a permanent registered manager since June 2019. During the inspection, staff told us that they did not always feel contained or empowered. We observed very busy staff who lacked direction and told us they were not always aware of their roles and responsibilities. During the inspection, we had difficulties getting the information that we requested as it was unclear which member of staff was responsible.
- The provider had not ensured patient safety was sufficiently prioritised. In the week before the inspection there was a significant patient against patient physical assault on Woodlands ward. Staff failed to provide adequate observation of the patients which allowed the attack to continue over a sustained period.
- Staff had not observed patients in the communal areas in line with the provider's policy and failed to correctly complete patient observation records. Staff recordings of patient activity did not correlate with CCTV footage. We had serious concerns that staff had failed to record times correctly or had falsified observation records. This was raised as a safeguarding concern by the provider following our inspection.
- Staff failed to report all incidents that they had observed. We found at least two occasions where CCTV was reviewed and identified that staff had observed incidents and not reported them. This meant that there was a risk that patients had suffered harm and no immediate action had been taken to reduce the risk and protect patients from further harm.
- Senior staff did not have an effective process in place to review and learn from incidents. Since June 2019 we found there had been a high number of incidents. Staff on Cherry Oak ward recorded 133 incidents in July 2019 whilst there were four patients on the ward. On Woodlands ward for the same period there were 50 incidents. We were not assured of the accuracy of recording due to the points above.
- Staff use of restraint, and methods of restraint, were unsafe. Staff used restraint that was not proportionate and had failed to use least restrictive interventions, for example verbal de-escalation strategies, to manage risk incidents. CCTV footage showed staff using unapproved techniques and acting aggressively towards patients which compromised the safety of the patients. Agency staff used different methods to restrain patients than Priory-trained staff. This meant that restraints may not have been safely undertaken.
- Staff used restraint significantly more often, particularly on Cherry Oak ward. Last year, during a six-month period between 1 April 2018 and 30 September 2018 there was a total of 194 restraints carried out on Cherry Oak and Woodlands. In July 2019 there had been nearly the same amount in one month with staff reporting 147 incidents where restraint had been used.
- In the three months prior to the inspection, significant concerns had been raised to the Care Quality Commission by safeguarding authorities and other external stakeholders regarding the safety and welfare of young people at the hospital, particularly in relation to the high number of incidents, use of restraint and staff pre-employment checks. Safeguarding authorities had also raised concerns about the poor quality of safeguarding referrals they had received which had led to delays in triaging and investigation of incidents.
- Staff had not followed care plans for a patient who was being nursed in long-term segregation. During the inspection, we viewed CCTV footage which showed the patient in a communal area, to which they should not have had access due to the risk they posed. The nursing daily notes recorded that they were on grounds leave at that time.
- Managers did not have robust systems in place to ensure that staff pre-employment checks had been carried out and that staff were appropriately cleared to work within the hospital. We found that a member of staff was able to work whilst under investigation and, earlier in the year, another member of staff was able to return to work whilst the investigation into their conduct was ongoing. These incidents raised concerns that managers had not put effective measures in place following the first incident, allowing the second incident to take place. In addition to this, managers did not have effective systems to ensure they were

Summary of findings

aware of any issues declared on agency staff's disclosure and barring service check. This resulted in a member of staff working there who had not been effectively risk assessed.

- The provider did not have adequate levels of staffing to work on the wards and to provide an effective multidisciplinary service. We were concerned that improvements in staffing observed during our last inspection in June 2019 had not been maintained and the ability of the hospital to employ and retain enough, suitably qualified and skilled staff had deteriorated. Our concerns were exacerbated by significant numbers of staff not arriving on site to work or cancelling shifts at the last minute. Key members of the multidisciplinary team had resigned, including the medical director, the newly appointed social worker, an occupational therapist and a play therapist.
- Staff had not sustained recent improvements in incident reporting. Staff failed to record all incidents on the provider incident reporting system and had not updated patients' risk assessments after incidents had taken place. Staff had not added 22 paper incident records dating back from 18 July 2019 on Cherry Oak ward to the electronic incident reporting system. Managers had not reviewed a significant number of incidents on the reporting system. We were concerned that managers did not have effective oversight to ensure this work was completed or did not provide effective learning to take place to minimise the risk of repeated incidents. This resulted in staff not having robust risk assessments in place in order to safely manage the risk posed by patients to themselves or others.
- During July and August 2019, supervision rates for staff dropped to 33% for nursing staff. During this time, we noted an increased acuity on the wards and staff would have particularly needed support at this time. The quality of supervision records we did review demonstrated emphasis on conduct issues and lacked evidence of discussion of wellbeing or clinical discussion to improve practice. We were concerned that, due to the lack of supervision, staff's stress levels had increased and promoted a culture for poor practice to develop.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	Cherry Oak Woodlands

Summary of findings

Contents

Inadequate

Ellingham Hospital

Services we looked at
Child and adolescent mental health wards.

Summary of this inspection

Background to Ellingham Hospital

Ellingham hospital has the capacity to care for up to a total of 44 patients. Two wards accommodate patients aged from 4 to 18 years, and two acute wards accomodate adults of working age. The service is registered with CQC for assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder, or injury.

Ellingham hospital has four wards; Cherry Oak is a secure ward (CAHMS) and Woodlands is a Tier 4 ward (CAMHS). Redwood One, and Redwood Two are both acute wards for working age adults. There is an on-site school. The school is Ofsted registered and was rated 'Good' in 2016.

Cherry Oak ward is a specialist 10-bedded low secure inpatient ward for patients aged from 4 to 18 years with conditions such as complex neuro-developmental disorder, learning disability, attention deficit hyperactivity disorders and mental health problems. At the time of inspection there were four patients on the ward and all patients were detained under the Mental Health Act 1983.

Woodlands ward is a specialist inpatient ward that cares for patients aged from 4 to18 years with psychiatric, emotional, behavioural and social difficulties, including learning disabilities and autism spectrum disorder. It is a mixed-gender ward and has 10 beds. At the time of the inspection, there were four patients on the ward. Patients could be detained under the Mental Health Act or were informal.

Following a comprehensive inspection in January 2019, the CQC issued a warning notice against one regulation of the Health and Social Care Act. This was issued in January 2019 against Regulation 18 HSCA (RA) Regulations 2014 staffing:

- The provider did not deploy enough suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).

The CQC also issued a requirement notice against three regulations of the Health and Social Care Act: These were issued in January 2019 against Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment, Regulation 17 HSCA (RA) Regulations 2014 Good governance and Regulation 18 HSCA (RA) Regulations 2014 Staffing:

- The provider must ensure that observations were carried out safely and recorded appropriately.
- The provider must ensure that staff fully complete documentation of managing violence and aggression incidents.
- The provider must have sufficient systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.
- The provider must demonstrate evidence of communication to staff and patients of lessons learnt from incidents and complaints.
- The provider must ensure that locum doctors providing out of hours cover had the appropriate training and knowledge to provide clinical expertise when reviewing patient clinical risk.

Following a focussed inspection on 26th June 2019, the warning notice for staffing was removed following improvements in staffing and improvements were noted in incident recording and training for locum doctors. A further requirement notice was issued against Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment:

- The provider did not ensure that body maps were completed, or recorded as inappropriate, after every incident.
- The provider did not ensure that staff always followed the Priory observation policy and procedures to ensure that observations sheets were being correctly signed and counter-signed.
- The provider did not ensure that staff labelled opened bottles of medicine with the date of opening.

Prior to inspection, the Priory Group, in consultation with NHS England, had made a decision to close Cherry Oak ward and seek alternative placements for the young people on the ward. This was due to concerns of the provider in its ability to recruit and retain suitably qualified and skilled nursing the healthcare staff in order to provide safe care for patients with complex needs. No

Summary of this inspection

definite timescales had been agreed between the provider and NHS England for this closure. During this inspection, we issued a notice of decision advising that there could be no further admissions to both Cherry Oak and Woodlands wards, and that Woodlands ward must also close as we are not assured that the service could keep any of the young people safe.

Our inspection team

The team that inspected the service was comprised of three CQC inspectors and a CQC inspection manager.

Why we carried out this inspection

This focussed inspection was carried out following significant concerns raised by external stakeholders regarding the safety of patients on the child and adolescent mental health wards at the hospital, particularly Cherry Oak ward.

How we carried out this inspection

This was a focussed, unannounced inspection. Throughout this inspection, the Care Quality Commission continued to monitor the safety and wellbeing of the young people who used the service. The hospital worked with NHS England (who are the commissioners of the service) to move all of the young people from the hospital in a safe and controlled manner. Oversight was also provided by the Local Authority and the Norfolk Clinical Commissioning Group. At the time of this report, NHS England were continuing to source alternative beds for some of the young people with complex needs.

We asked the following key questions:

- Is it safe?
- Is it caring?
- Is it well led?

During the inspection visit, the inspection team:

- spoke with the Operations Director, the interim Hospital Director and ward managers for Cherry Oak and Woodlands wards;
- spoke with eleven other staff members; including doctors, nurses, healthcare workers, a member of the multidisciplinary team and administrative and support staff;
- spoke with two patients who were using the service;
- spoke with one carer of a patient who was using the service;
- checked the clinic room and medicine management on Cherry Oak ward;
- looked at five care and observation records;
- viewed CCTV footage of seven incidents across both wards;
- attended an early morning review meeting and a care programme approach review for a patient;
- spoke with several external safeguarding representatives, including from NHS England, the local safeguarding authority, Norfolk children's services, the Clinical Commissioning Group and the independent advocate for the hospital and
- looked at a range of policies, procedures and other documents relating to the running of the service, including clinical governance meeting minutes, staffing rotas and training and supervision records.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- The provider had not ensured patient safety. In the week prior to the inspection there was a significant patient against patient physical assault on Woodlands ward. There was inadequate observation of patients by staff which allowed the attack to continue over a sustained period in an area which should have had staff presence. Staff recording of patient activity did not correlate with CCTV footage which raised serious concerns that staff had failed to record times correctly or had falsified observation records. There was a delay in staff pro-actively investigating the cause of the victim's injuries. We could not be assured that other incidents had happened but gone unnoticed.
- Improvements in staffing observed during our last inspection in June 2019 had not been maintained and the ability of the hospital to employ and retain enough, suitably qualified and skilled staff had deteriorated over the summer period. There had been several recent resignations of key staff, including the medical director, the newly appointed social worker, one of the two occupational therapists and a play therapist. The provider also continued to hold vacancies for psychology staff. This impacted on the provider's ability to provide an effective multidisciplinary service with motivated, permanent staff who were familiar with the service and the patients.
- Staff completed a risk assessment for each patient when they were admitted and reviewed them at regular intervals. However, staff did not update these assessments in a timely manner after incidents. For example, on Cherry Oak ward we saw where a serious assault upon a member of staff by a patient was not updated in the patient's risk assessment until 11 days after the incident. During the inspection, we saw care records for a patient on Cherry Oak ward where risk assessments were not updated at all after a number of incidents. By not adding the incident to the risk assessment, staff would not have a complete and up-to-date record from which to assess the risks to the patients and to others.
- Staff had not carried out observations correctly and in accordance with Priory policy which seriously impacted on patient safety. During the inspection, we found evidence that observation sheets contained information that was not consistent with CCTV footage from the ward or with daily

nursing notes. During a serious incident that occurred on Woodlands ward in the week before the inspection, staff had recorded the young people involved as settled and involved in activities during the time of the incident. This did not correlate with CCTV records we viewed.

- We were not assured that information contained within clinical records was accurate. We saw conflicting accounts and omission of information in observation records and incident reports. This meant clinicians reviewing patients were doing so with unreliable information and potentially making incorrect clinical decisions regarding the young person's care and treatment.
- Staff's use of restraint, and methods of restraint, were unsafe. Staff used restraint that was not proportionate and had failed to use least restriction interventions, for example verbal de-escalation strategies, to manage risk incidents. CCTV footage showed staff using unapproved techniques and acting aggressively towards patients which compromised the safety of the patients. Agency staff used different methods to restrain patients than Priory-trained staff. This meant that restraints may not have been safely undertaken.
- Staff used restraint significantly more often, particularly on Cherry Oak ward. Last year, during a six-month period between 1 April 2018 and 30 September 2018 there was a total of 194 restraints carried out on Cherry Oak and Woodlands. In July 2019 there had been nearly the same amount in one month with staff reporting 147 incidents where restraint had been used.
- Managers did not have robust systems in place to ensure that staff pre-employment checks had been carried out and that staff were appropriately cleared to work within the hospital. We found that a member of staff was able to work whilst under investigation and, earlier in the year, another member of staff, was able to return to work whilst the investigation into their conduct was ongoing. These incidents raised concerns that managers had not put effective measures in place following the first incident, allowing the second incident to take place. In addition to this, managers did not have effective systems to ensure they were aware of any issues declared on agency staff's disclosure and barring service check. This resulted in a member of staff working there who had not been effectively risk assessed.
- We were concerned about the increased number of incidents being reported that involved allegations of improper conduct by staff, some of which had led to staff being suspended or

Summary of this inspection

dismissed. In the three months prior to the inspection, we had been notified by the provider, and the safeguarding authorities, of 12 incidents involving allegations against staff ranging from staff having a poor attitude towards patients, using unapproved restraint techniques, being verbally aggressive towards patients and not reporting when they had witnessed incidents of poor conduct by colleagues.

- Recent improvements in incident reporting had not been sustained. We saw that incidents were not always recorded on the provider incident reporting system and that not all incidents were added into the patient's risk assessment. We found 22 paper incident records dating back from 18 July 2019 on Cherry Oak that had not yet been added to the reporting system. We also saw significant number of incidents on the reporting system that had not been reviewed by a manager. We were not assured there was effective oversight to ensure this work was completed as required to enable effective learning to take place.

Are services effective?

We did not inspect this key question at this inspection.

Are services caring?

Inadequate

We rated caring as inadequate because:

- Staff did not always treat the young people with kindness, dignity and respect. In the three months prior to the inspection, managers and the safeguarding authorities had notified us of a number of incidents where staff had been unkind, aggressive or heavy-handed towards patients. We saw evidence of CCTV footage where the use of restraint was not always proportionate and there was little evidence of attempts to de-escalate using least restrictive interventions. We saw methods used that were not taught and compromised the safety and dignity of the young people.
- Managers notified us of two incidents where staff had witnessed colleagues demonstrating aggression or a lack of caring towards patients but had not reported this to their managers. We were concerned that a culture was developing where staff accepted poor practise and did not prioritise the needs and safety of the patients.
- Managers we spoke with told us that some staff were burnt out and in a high state of alert which meant they did not always respond in a professional or caring way towards the young people on the wards, or they retaliated inappropriately when they were abused or assaulted by unsettled patients.

Summary of this inspection

Are services responsive?

We did not inspect this key question at this inspection.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- There had been a prolonged period without a consistent and stable leadership team in place at the hospital. At the time of the inspection, an interim hospital director had just been appointed as the provider had not been able to recruit a permanent member of staff into this position. During the inspection, staff told us that they did not always feel contained or empowered. We observed very busy staff who lacked direction and told us they were not always aware of their roles and responsibilities.
- Governance structures in place were not consistent or robust to provide adequate oversight and monitoring of the quality and safety of services provided. For example, we found examples where observation records had not been completed accurately which could impact on the assessment and safety of patients. We were concerned that managers did not have sufficient oversight of staff observations to ensure these were being completed consistently in accordance with the Priory policy.
- We were not assured that managers had effective oversight of incident reporting. We saw a backlog of incident reports had built up again on Cherry Oak ward. We found 22 paper incident records dating back from 18 July 2019 on Cherry Oak ward that had not yet been added to the reporting system. We also saw a significant number of incidents on the reporting system that had not been signed off by a manager dating back from the beginning of August 2019.
- The provider had not consistently safeguarded all patients from abuse. There had been 12 incidents reported in the three months prior to the inspection involving allegations of staff verbal or physical abuse against patients. Some of the incidents had been unsubstantiated or were still under investigation, however four of these incidents had been substantiated by CCTV footage and had led to staff members being suspended or dismissed. We were not assured that systems were robust to ensure staff were appropriately cleared to work before they were employed or allowed to return to work following suspension.
- We were not assured that senior managers had sufficient oversight of safeguarding referrals. Safeguarding officials told us that often referrals had been poorly completed and there had been difficulties in conducting investigations due to delays in accurate information being received from the provider,

despite being requested multiple times. The safeguarding authority also raised a concern that ward staff completing referrals may not have had all the correct information, and these should be completed by more senior staff. One incident reported to safeguarding had not been reported to the CQC as required by our notification policy.

- Managers did not have sufficient oversight of the safe use of restraint. Restraints were not always proportionate and there was little evidence of attempts to de-escalate using least restrictive interventions. Managers confirmed that agency staff had received different models of Prevention and Management of Violence and Aggression (PMVA) training to Priory-trained staff which meant that restraints may not have been safely undertaken. The concern was first discussed 12 months ago within the Priory Group and a plan was agreed at the time but not implemented. We were concerned that managers had not treated actions from this plan with sufficient urgency which compromised the welfare of patients.
- The provider failed to ensure that there was always enough skilled and experienced staff on the wards to meet the needs of the young people. The ability of the provider to employ and retain enough, suitably qualified staff had deteriorated over the summer months. This was exacerbated by significant numbers of staff not arriving on site to work or cancelling shifts at the last minute. There had also been several resignations of key staff, including the medical director, the newly appointed social worker, an occupational therapist and a play therapist.
- Managers told us that poor performance by some staff, for example repeatedly not turning up for work, had not been addressed in a timely manner allowing this to continue. Agency staff had been able to continue working at the hospital despite concerns about their reliability and permanent staff had not been subject to appropriate disciplinary procedures for poor performance such as cancelling shifts at the last minute or leaving the site without authorisation.
- Managers were not ensuring that all staff had regular supervision. During July and August 2019, we saw evidence that the supervision rates for staff dropped to 33% for nursing staff. The quality of supervision records we did review demonstrated emphasis on conduct issues and lacked evidence of discussion of wellbeing or clinical discussion to improve practice. Lack of supervision can increase stress and provide a culture for poor practice to develop.

Summary of this inspection

- The systems to ensure staff were appropriately cleared to work before they were employed or allowed to return to work following suspension were not robust. We saw that one member of staff worked a shift whilst under suspension. This follows two previous serious incidents earlier in the year where safeguarding authorities raised concerns about Ellingham's safe recruitment process. In December 2018, managers allowed a staff member to return to work whilst being investigated for a serious safeguarding incident. In April 2019 the provider recruited a member of agency staff who had previous allegations made against him.

Detailed findings from this inspection

Notes

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Effective	
Caring	Inadequate
Responsive	
Well-led	Inadequate

Are child and adolescent mental health wards safe?

Inadequate

Safe staffing

Managers had not maintained improvements in staffing that we observed during our last inspection in June 2019. The ability of the hospital to employ and retain sufficient, suitably qualified and skilled staff had deteriorated over the summer period. There had been several recent resignations of key staff, including the medical director, the newly appointed social worker, one of the two occupational therapists and a play therapist. The provider also continued to hold vacancies for registered nurses, a permanent hospital director and psychology staff. This impacted on the provider's ability to provide an effective multidisciplinary service with motivated, permanent staff who were familiar with the service and the patients.

The provider reported that during the summer period, there was a high number of nursing and healthcare staff who did not arrive for work or cancelled shifts with very short notice. Managers provided figures that showed between 26 August 2019 and 4 September 2019 44 members of staff had either not arrived for work without giving an explanation or cancelled a shift at the last minute. Of these 44 members of staff, 29 were due to work on Cherry Oak ward and seven were due to work on Woodlands ward. The provider was unable to find cover for 18 shifts during this period. On one occasion in August, Cherry Oak ward was three members of staff down.

Managers told us this had also happened frequently earlier on in the summer. We were concerned that this impacted on the provider's ability to provide a safe number of staff to work on the wards.

The service had high use of bank and agency nurses and healthcare assistants to cover sickness, absence or vacancy for staff. Managers confirmed that the provider accepted agency staff with no specialist training in working with children and adolescents with complex needs. We remained concerned that this impacted on the ability of the service to provide specialist care for the young people at the hospital as staff did not have had the skills and experience to work with this complex patient group. Some bank and agency staff had worked at the hospital for between six months and two years so were familiar with the service and the patients. Wherever possible, managers booked these staff. However, there were occasions where patients, many of whom had attachment disorders, had unfamiliar staff working with them.

The service provided all permanent, bank and agency staff with an induction and offered support and supervision. However, we were concerned that supervision rates were very low over the summer period. Figures provided by the hospital, showed that 54% of nursing and healthcare staff received supervision in July 2019 and 33% of nursing and healthcare staff received supervision in August 2019. During this time period there was a high number of incidents and restraints on the wards and staff would have particular need for support at this time. The quality of supervision records we did review demonstrated emphasis on conduct issues and lacked evidence of discussion of wellbeing or clinical discussion to improve practice. We were concerned that, due to the lack of supervision, staffs stress levels had increased and promoted a culture for poor practice to develop.

Inadequate

Child and adolescent mental health wards

The establishment staffing figures were not sufficient to provide enough cover across the child and adolescent mental health wards over the summer period. A high number of staff were not arriving for work and there was increased acuity on the wards, particularly Cherry Oak ward. Whilst managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift, staff we spoke with told us that they were sometimes moved across wards to cover gaps as necessary. We were concerned that, in addition to the staffing issues, the school was closed which resulted in staff being required to provide meaningful activities to the patients on the wards.

Nursing and healthcare staff we spoke with, told us they were usually getting their breaks, however there were times when they missed a break, or one was shortened. This was usually because of an incident or because another member of staff had not arrived for work.

Medical staff

At the time of the inspection there were enough doctors to provide medical cover over a 24-hour period. The provider employed two permanent consultant psychiatrists and locum staff to cover at night. However, one of the consultant psychiatrists, who was also the medical director for the hospital, had recently resigned from their position. The provider had plans in place to recruit a locum consultant until a permanent replacement could be found.

Assessing and managing risk to patients and staff

Staff had not managed risk to young people effectively or protected young people from harm. Whilst staff reacted to incidents on the wards, they failed to prevent incidents occurring or escalating.

Staff completed a risk assessment for each patient when they were admitted and reviewed them at regular intervals. However, staff did not update these assessments in a timely manner after incidents. For example, on Cherry Oak ward we saw where a serious assault upon a member of staff by a patient was not updated in the patient's risk assessment until 11 days after the incident. During the inspection, we saw care records for a patient on Cherry Oak ward where their risk assessments were not updated at all after a number of incidents. By not adding the incident to the risk assessment, staff would not have a complete and up to date record from which to assess the risks to the patients and to others.

Staff had not carried out observations correctly and in accordance with Priory policy which seriously impacted on patient safety. During the inspection, we found evidence that observation sheets contained information that was not consistent with CCTV footage from the ward or with daily nursing notes. During a serious incident that occurred on Woodlands ward in the week before the inspection, staff had recorded the young people involved as settled and involved in activities during the time of the incident. This did not correlate with CCTV records we viewed.

We were not assured that information contained within clinical records was accurate. We saw conflicting accounts and omission of information in observation records and incident reports. This meant clinicians reviewing patients were doing so with unreliable information and potentially making incorrect clinical decisions regarding the young person's care and treatment.

Staff used restraint significantly more often, particularly on Cherry Oak ward. Last year, during a six-month period between 1 April 2018 and 30 September 2018 there was a total of 194 restraints carried out on Cherry Oak and Woodlands. In July 2019 there had been nearly the same amount in one month with staff reporting 147 incidents where restraint had been used.

Staff use of restraint, and methods of restraint, were unsafe. Staff used restraint that was not proportionate and had failed to use least restriction interventions, for example, verbal de-escalation strategies, to manage risk incidents. CCTV footage showed staff using unapproved techniques and acting aggressively towards patients which compromised the safety of the patients.

Managers told us that some agency staff had received different models of Prevention and Management of Violence and Aggression (PMVA) training to Priory-trained staff. The provider told us they are beginning to address this, but the concern was first discussed 12 months ago within the Priory Group and a plan was agreed at the time. We were concerned that actions from this plan had only begun to be put into place prior to the inspection which meant that restraints may not have been safely undertaken. For example, there had been one incident where an agency member of staff confirmed that he had used a 'pinch' technique during a restraint. This is not a technique that is taught to Priory staff and staff would not

be expected to use this technique in any circumstances. Two staff members told us that agency staff who worked shifts often worked to a different culture and ethos and were trained in different methods of restraint.

The seclusion room did not contain a mattress or anti-rip blanket. This was raised as a concern during the inspection but had not been resolved several weeks later. During this time the seclusion room continued to be used, including on one occasion where a young person was secluded for a prolonged period of time and had to sit on the floor for the duration of the seclusion.

Safeguarding

Managers did not have robust systems in place to ensure staff were appropriately cleared to work before they were employed or allowed to return to work following suspension. We saw that in September 2019 one member of staff worked a shift whilst under suspension. This follows two previous serious incidents earlier in the year where safeguarding authorities raised concerns about Ellingham's safe recruitment process. In December 2018, managers allowed a staff member to return to work whilst being investigated for a serious safeguarding incident. In April 2019, the provider recruited a member of agency staff who had previous allegations made against them for assault against a child and inappropriate use of restraint. The agency had not checked or followed up the inappropriate references for this member of staff. We were concerned that effective measures were not put in place after the first incident and that patients were not being kept safe from staff who may pose a risk to young people.

We were concerned about the increased number of incidents being reported that involved allegations of improper conduct by staff, some of which had led to staff being suspended or dismissed. In the three months prior to the inspection we had been notified by the provider, and the safeguarding authorities, of 12 incidents involving allegations against staff ranging from staff having a poor attitude towards patients, using unapproved restraint techniques, being verbally aggressive towards patients and not reporting when they had witnessed incidents of poor conduct by colleagues.

Four of the above incidents were corroborated by CCTV footage viewed by the hospital managers, the safeguarding authority or CQC inspectors. Managers suspended or dismissed the staff members involved, including one incident where two staff members witnessed a member of staff being aggressive towards a patient, but did not report this or intervene.

Figures reported in clinical governance meeting minutes for July 2019 showed that 69% of staff had received face-to-face safeguarding training and 70% of staff had completed e-learning in safeguarding children.

Medicines management

We reviewed medicines management on Cherry Oak ward. Staff reviewed patient's medicines regularly and provided specific advice to patients.

Staff told us about one controlled drugs error on Woodlands ward. This had been raised as an incident and was currently under investigation.

The pharmacist completed regular audits and any actions identified were addressed. The pharmacist was available to give advice to doctors and nursing staff, including during out of office hours.

At the last inspection, the provider had not ensured that staff labelled opened bottles of medicine with the date of opening. We did not find any opened, unlabelled bottles at this inspection.

Reporting incidents and learning from when things go wrong

Managers had not sustained the recent improvements in incident reporting. Staff failed to record all incidents on the provider incident reporting system and did not update patients risk assessments after incidents had taken place. We found two occasions where CCTV footage identified that staff had observed incidents and not reported them. Staff had not added 22 paper incident records dating back from 18 July 2019 on Cherry Oak to the electronic incident reporting system. Managers had not reviewed a significant number of incidents on the reporting system. We were concerned that managers did not have effective oversight to enable effective learning to take place to minimise the risk of repeated incidents.

Staff discussed incidents and learning points in team meetings and monthly wellbeing centre meetings. A lesson learnt bulletin was published and shared with staff via e-mail and supervisors checked staff learning during individual supervision sessions. However, as the number of

Inadequate

Child and adolescent mental health wards

staff receiving regular supervision had fallen during the summer period, we were concerned that staff were not always able to have those discussions. Governance meeting minutes from 2 August 2019 stated the need for lessons learnt minutes to be more informative, including describing what incidents have been discussed. We were concerned that the improvement in the quality of discussion around lessons learnt which was noted at the last inspection had not been sustained. The provider had not taken effective action to investigate and address the findings of these investigations. Incidents continued to occur with no evidence of improvement.

There were no permanent psychology staff employed. Assistant psychology staff told us that they analysed incident form data and reported on trends at ward rounds and clinical governance meetings. However, the lack of psychology staff limited the amount of time that could be spent disseminating and embedding this information and staff told us that there was a lack of understanding of the role of members of the multidisciplinary team amongst some nursing staff. Psychology staff were not available to conduct debriefs with staff after incidents, so this was being done by ward managers and nurses who already had very busy roles. We were concerned that this had an impact on how effectively lessons learnt and themes could be identified and shared. Although we acknowledge that the lack of psychologist was due to challenges in recruitment.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

We did not inspect this key question at this inspection.

Are child and adolescent mental health wards caring?

Inadequate

Staff did not always treat the young people with kindness, dignity and respect. In the three months prior to the inspection, managers and the safeguarding authorities had notified us of a number of incidents where staff had been unkind, aggressive or heavy-handed towards patients. We saw evidence of CCTV footage where the use of restraint was not always proportionate and there was little evidence of attempts to de-escalate using least restrictive interventions. We saw methods used that were not taught and compromised the safety and dignity of the young people.

Managers notified us of two incidents where staff had witnessed colleagues demonstrating aggression or a lack of caring towards patients but had not reported this to their managers. We were concerned that a culture was developing where staff accepted poor practise and did not prioritise the needs and safety of the patients.

CCTV footage viewed demonstrated poor care by staff, inappropriate responses when responding to young people in heightened distress and acts of intimidation.

Managers we spoke with told us that some staff were burnt out and in a high state of alert which meant they did not always respond in a professional or caring way towards the young people on the wards, or they retaliated inappropriately when they were verbally abused or assaulted by unsettled patients.

However

During the inspection, we observed some positive interactions between staff and patients and some staff we spoke with demonstrated knowledge of patients and their needs.

We observed some committed staff, including multi-disciplinary team staff, working in a challenging environment to care for and support young people with complex needs. External stakeholders also told us about their experience of working with compassionate staff at the hospital who demonstrated respect and kindness for the young people in their care.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

We did not inspect this key question at this inspection.

Are child and adolescent mental health wards well-led?

Inadequate

Child and adolescent mental health wards

Inadequate

Leadership

Managers failed to provide a consistent and stable leadership team over a prolonged period of time. At the time of the inspection, an interim hospital director had just been appointed as the provider had not been able to recruit a permanent member of staff into this position. During the inspection, staff told us that they did not always feel contained or empowered. We observed very busy staff who lacked direction and told us they were not always aware of their roles and responsibilities.

Governance

Governance structures in place were not consistent or robust to provide effective oversight and monitoring of the quality and safety of services provided.

The previous improvement observed in managers oversight of incidents since the last inspection had not been sustained. Managers had not ensured that staff used the correct procedure for reporting incidents in a timely manner. In addition to this, we saw a significant number of incidents on the reporting system that had not been signed off by a manager dating back from the beginning of August 2019.

Senior staff did not have an effective process in place to review and learn from incidents. Since June 2019 we found there had been a significant increase in incidents. Staff on Cherry Oak ward recorded 133 incidents in July 2019 whilst there were four patients on the ward. On Woodlands ward for the same period there were 50 incidents. We were not assured of the accuracy of recording due to the points above. We do however acknowledge the patient group had complex needs on these wards.

Staff told us they were not always clear about their roles and accountabilities and changes in leadership made it difficult to be confident about processes and procedures and their responsibilities in relation to these.

The provider failed to consistently safeguard all patients from abuse. There had been 12 incidents reported in the three months prior to the inspection involving allegations of staff verbal or physical abuse against patients. Some of the incidents had been unsubstantiated or were still under investigation. However, four of these incidents had been substantiated by CCTV footage and had led to staff members being suspended or dismissed. We were not assured that systems were robust to ensure staff were appropriately cleared to work before they were employed or allowed to return to work following suspension.

Safeguarding authorities carried out an initial investigation into all reported safeguarding incidents, however they told us that there had been difficulties in concluding some of their investigations due to delays in accurate information being received from the provider, despite being requested multiple times. The safeguarding authority also raised a concern that staff without the appropriate skills were completing referrals and these staff may not have had all the correct information. The view of the safeguarding team was there was a lack of effective senior management oversight to ensure information provided was accurate and completed in a timely manner.

Managers did not have sufficient oversight of the safe use of restraint. We saw evidence of CCTV footage where the use of restraint was not always proportionate and there was little evidence of attempts to de-escalate using least restrictive interventions. Managers confirmed that agency staff had received different models of Prevention and Management of Violence and Aggression (PMVA) training to Priory-trained staff which meant that restraints may not have been safely undertaken. The concern was first discussed 12 months ago within the Priory Group and a plan was agreed at the time but not implemented. We were concerned that managers had not treated actions from this plan with sufficient urgency which compromised the welfare of patients.

The provider failed to ensure there was always sufficient numbers of skilled and experienced staff on the wards to meet the needs of the young people. The ability of the provider to employ and retain sufficient, suitably qualified staff had deteriorated over the summer months. This was exacerbated by significant numbers of staff not arriving on site to work or cancelling shifts at the last minute. There had also been several resignations of key staff, including the medical director, the newly appointed social worker, an occupational therapist and a play therapist. The provider also continued to hold vacancies for psychology staff. This impacted on the ability of the service to maintain a safe number of staff upon the ward and to provide an effective multi-disciplinary service.

Clinical governance monthly meetings were being held regularly as planned, and managers had recently made a change to the minutes to reflect actions outstanding and dates for completion.

Culture

We spoke with 11 members of staff. Staff told us that morale at the hospital fluctuated. Three members of staff told us that the lack of consistent leadership had affected morale. Staff morale was lower on Cherry Oak ward where staff were carrying out high intensity observations for longer than two hours unlike staff on the other wards, and there were a higher number of incidents of violence and aggression against staff. However, staff told us this had improved since the transfer of a Priory ward manager (who was considering joining the team) as he was approachable and supportive. Four members of staff told us they enjoyed working at the hospital and felt supported by their colleagues and managers.

Staff we spoke with told us they felt able to raise concerns without fear of retribution and knew about the whistle-blowing process.

We were concerned that a culture was developing where staff accepted poor practise and did not prioritise the needs and safety of the patients. Managers had not identified this as a concern and had not taken sufficient action to address poor performance and reducing morale.

We were told there was a lack of understanding, trust and cohesive working between some nursing and multidisciplinary team (MDT) staff. This had an impact on the ability of the service to provide an effective multi-disciplinary service for the benefit of patients.

Managers did not have sufficient oversight of the seclusion room. The seclusion room did not contain a mattress or anti-rip blanket. This was raised as a concern during the inspection, but managers had not ensured this was rectified. During this time, the seclusion room continued to be used, including on one occasion where a young person was secluded for a prolonged period of time and had to sit on the floor for the duration of the seclusion.

Management of risk, issues and performance

Managers failed to address poor performance by some staff in a timely manner. For example, some staff had repeatedly not turned up for work, cancelled shifts at the last minute or left the site without authorisation. Due to managers not effectively addressing these issues the behaviour of staff continued.

Managers failed to ensure that staff had access to regular, good quality supervision. During July and August 2019, we saw evidence that the supervision rates for staff dropped to 33% for nursing staff. The quality of supervision records we did review demonstrated emphasis on conduct issues and lacked evidence of discussion of wellbeing or clinical discussion to improve practice. Lack of supervision can increase stress and provide a culture for poor practice to develop.

Systems were not robust to ensure staff were appropriately cleared to work before they were employed or allowed to return to work following suspension. We saw that in September 2019 one member of staff worked a shift whilst under suspension. This follows two previous serious incidents earlier in the year where safeguarding authorities raised concerns about Ellingham's safe recruitment process. In February 2019, managers allowed a staff member to return to work whilst being investigated for a serious safeguarding incident. In April 2019 the provider recruited a member of agency staff who had previous allegations made against him. We were concerned that the provider was not keeping patients safe from staff who may pose a risk to young people.

Managers had not ensured the risk register was up to date and reflective of the current risk issues. There were still risks identified on the plan dating back to December 2016 which had not been updated and it was unclear whether these reflected current or ongoing risks.

Learning, continuous improvement and innovation

Although some staff were keen to improve services, managers told us that due to the current challenges faced by the service, staff were currently 'firefighting' and did not have time to step back and consider improvements and innovation, or participate in research, that could be put in place to improve quality of services.

The provider had demonstrated some improvements at the time of the last focussed inspection in June 2019, however these improvements had not been sustained. For example, we observed a decline in staffing, the quality of incident reporting and management oversight of observations and updating of risk assessments.

Outstanding practice and areas for improvement

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Notice of Decision served under Section 31 of the Health and Social Care Act 2008. 1.The Registered Provider must not admit CAMHS (Child and Adolescent Mental Health Services) inpatient services at Ellingham Hospital (specifically Cherry Oak and Woodlands Wards). 2. The Registered Provider must provide the Care Quality Commission with an action plan for the safe, controlled and timely move of all service users who receive the regulated activities under the CAMHS at Ellingham Hospital specifically Cherry Oak Ward and Woodlands Ward to an alternative service provider working in collaboration with NHS England (NHSE) by 4pm on Monday 9 September 2019. This must include: • A detailed, proposed plan including, where possible, the estimated move date for each patient. • Confirmation that handover arrangements are in place in anticipation of all planned moves. • Confirmation of the arrangements that have been put in place to ensure that all remaining patients are provided with safe care and treatment at all times by staff who have the relevant qualifications, competence, skills and experience.