Royal Hospital for Neuro-Disability

Quality Report

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Date of inspection visit: 5-6 and 10-11 February 2020
Date of publication: 15/07/2020

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Hospital for Neuro-Disability (RHN) is an independent medical charity which provides neurological services to the entire adult population of England. The hospital specialises in the care and management of adults with a wide range of neurological problems, including those with highly dependent and complex care needs, people in a minimally aware state, people who may demonstrate challenging behaviour, and people needing mechanical ventilation.

At our last comprehensive inspection in March and April 2017, this provider was rated as Good overall. Safe was rated as Requires Improvement. All other key questions were rated as Good. We also conducted focused inspections in July 2018 and November 2019, but we did not rate the service in our reports of these inspections.

This is a report of a comprehensive inspection we carried out on 5-6 and 10-11 February 2020.

Services we rate

Our rating of this hospital went down. We rated it as **Requires improvement** overall.

We found the following issues that the service provider needs to improve:

- The service provided mandatory training in key skills, but overall staff compliance fell slightly below the hospital's target of 95%.
- We could not be assured that all staff fully understood how to protect patients from abuse. The service did not always refer safeguarding concerns to other agencies when required. Most staff had training on how to recognise and report abuse, but some key staff were not trained to a sufficient level for the role they were carrying out.
- The service did not consistently manage patient safety incidents well. Staff reported incidents and near misses but did not always recognise when a safeguarding referral was required.
- Not all leaders had the necessary skills and abilities to run the service. Some did not always demonstrate that they fully understood and managed the challenges of leading this type of service.
- Leaders did not always operate effective governance processes, throughout the service or with partner organisations.
- Mitigation actions to address safeguarding risks were not always robust.
- We found three examples of incidents where the hospital did not notify external organisations as required.

However, we found the following areas of good practice:

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept detailed records of their assessments. They managed medicines well. Staff collected safety information and used it to improve the service. Managers investigated incidents. There was a system to share lessons learned with the whole team and the wider service, but this was not yet fully embedded.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Ward staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their condition. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for most people to give feedback. People could access the service when they needed it. We saw many examples of responsive practice from staff to meet patient's individual needs and provide holistic care.
- Executive team members were visible and approachable in the service for patients and staff, and they supported staff to take on more senior roles. Local leaders were experienced, skilled and understood the priorities and issues their wards faced.

Summary of findings

- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (London & South)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long term conditions	Requires improvement 	We rated Safe and Well Led as Requires Improvement, with Effective, Caring and Responsive rated as Good. This led to an overall rating of Requires Improvement.

Summary of findings

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Royal Hospital for Neuro-Disability

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Summary of this inspection

Background to Royal Hospital for Neuro-Disability

The Royal Hospital for Neuro-Disability (RHN) is a residential independent hospital run by a charity. It is located in Putney, West London. Patients and residents come mainly from London and southern England, but some come from other parts of England. RHN has a total of 237 beds across 13 wards, which are arranged in to three service lines; a brain injury service, continuing care, and specialist services. In the brain injury service, the hospital provides acute assessment and rehabilitation for up to 48 patients with severe brain injuries or illness through the NHS England Specialist Rehabilitation Contract. In the specialist services, the hospital provides specialist help to patients with a wide range of complex neurological disabilities caused by damage to the brain or other parts of the nervous system as a result of brain haemorrhage, traffic accidents or progressive neurological conditions. This includes care and treatment of people who are highly dependent and have complex care needs, people in a minimally aware state, people with complex behavioural needs, and people needing mechanical ventilation. In the continuing care service, the hospital provides long term care for 121 people who have become disabled following a brain injury. Therefore, for many people the hospital is their home and they are referred to as residents.

RHN is registered to provide diagnostic and screening activities, treatment of disease, disorder or injury, accommodation for people needing nursing or personal care and transport, triage and medical advice provided remotely. The chief executive has been the registered manager since March 2018.

RHN employed 11 doctors on a mix of full time, part time and zero hours contracts, and 0.45 whole time equivalent (WTE) dentists. A Wandsworth-based GP provides medical services to residents of the continuing care service and residents with Huntington's disease.

RHN employed 55 WTE qualified allied health professionals and 18 WTE support allied health professionals. This included physiotherapists, speech and language therapists and occupational therapists.

RHN employed 127 WTE registered nurses and 192 WTE healthcare assistants, as well as having its own bank staff to cover staffing shortfalls.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, an assistant inspector, an inspection manager, head of hospital inspection, CQC national safeguarding advisor, a physiotherapist specialist advisor, governance specialist advisor and an expert by experience. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

During the inspection, we visited the following wards; Andrew Reed, Chatsworth, Coombs, Devonshire, Drapers, Glyn, Hunter, The Jack Emerson Centre (ventilator unit), Wellesley and Wolfson.

We spoke with 40 members of staff including registered nurses, health care assistants, reception staff, allied health professionals, medical staff, and senior leaders. We spoke with three patients and six relatives. During our inspection, we reviewed 19 sets of patient 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?

Requires improvement

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- The service provided mandatory training in key skills, but overall staff compliance fell slightly below the hospital's target of 95%.
- We could not be assured that all staff fully understood how to protect patients from abuse. The service did not always refer safeguarding concerns to other agencies when required. Most staff had training on how to recognise and report abuse, but some key staff were not trained to a sufficient level for the role they were carrying out.
- The service did not consistently manage patient safety incidents well. Staff reported incidents and near misses but did not always recognise when a safeguarding referral was required.

However, we also found the following areas of good practice:

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept detailed records of their assessments.
- The hospital managed medicines well, and staff collected safety information and used it to improve the service.
- Managers investigated incidents. The head of nursing had initiated a system to share lessons learned with the whole team and the wider service, but this was not yet fully embedded.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Ward staff worked well together for the benefit of patients and supported them to make decisions about their care.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

Summary of this inspection

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Are services responsive?

Good 

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for most people to give feedback.
- We saw many examples of responsive practice from staff to meet patient's individual needs and provide holistic care.
- People could access the service when they needed it.

Are services well-led?

Requires improvement 

Our rating of well-led went down. We rated it as **Requires improvement** because:

- Not all leaders had the necessary skills and abilities to run the service. Some did not always demonstrate that they fully understood and managed the challenges of leading this type of service.
- Leaders did not always operate effective governance processes, throughout the service or with partner organisations.
- Mitigation actions to address safeguarding risks were not always robust.
- We found three examples of incidents where the hospital did not notify external organisations as required.

However, we also found the following areas of good practice:

- Executive team members were visible and approachable in the service for patients and staff, and they supported staff to take on more senior roles. Local leaders were experienced, skilled and understood the priorities and issues their wards faced.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long term conditions	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Requires improvement

Long term conditions

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

Are long term conditions services safe?

Requires improvement

Our rating of safe stayed the same.We rated it as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills, but overall staff compliance fell slightly below the hospital's target of 95%.

Mandatory training was provided face to face and online. Face to face training included manual handling, safeguarding levels one two and three, fire safety, Mental Capacity Act/Deprivation of Liberty Safeguards and cardio-pulmonary resuscitation. Online training included drug calculation, intravenous training, equality diversity and human rights, use of the National Early Warning Score (NEWS2), Duty of candour, infection prevention and control, general data protection regulations, health and safety, and dysphagia (difficulty swallowing). Staff were given time off to complete training. Mandatory training updates were required annually, apart from safeguarding levels above the level one e-learning, which were required every three years.

Mandatory training compliance was monitored by the learning and development department. A ward manager told us they received monthly updates on the mandatory training compliance rate for their ward. The hospital provided us with mandatory training compliance rates as of 6 December 2019, as part of their provider information request. This showed the overall percentage of staff who had completed mandatory training was 91%, slightly below the hospital's target of 95%. In this document, there were some areas of low compliance. The document showed safeguarding level 1A training for clinical staff was at 68% and cardio-pulmonary resuscitation for non-clinical staff was at 25%.

Following our inspection, the provider submitted data that showed overall compliance with safeguarding level 1A had increased to 79%, and cardio-pulmonary resuscitation had increased to 89%. By the end of the training year on 31 December 2019, overall compliance with mandatory training was at 93%.

During our visits to the wards, staff told us that access to mandatory training was good, and they were supported to complete it. There was an incentive scheme whereby staff could gain an extra day of leave if they completed all mandatory training modules and maintained their compliance. We viewed mandatory training records for staff on Hunter ward during our inspection, which showed 17 of 22 staff working on the ward were up to date with all modules.

Staff could view the mandatory training records for agency workers on an electronic system. A matron told us agency staff working at the hospital must complete the in-house mandatory training and must provide evidence that they were compliant before they could be booked on to shifts.

Safeguarding

We could not be assured that all staff fully understood how to protect patients from abuse. The service did not always refer safeguarding concerns

to other agencies when required. Most staff had training on how to recognise and report abuse, but some key staff were not trained to a sufficient level for the role they were carrying out.

All staff were required to complete mandatory training for safeguarding adults and children, as outlined in the provider's policies. The provider told us that all staff received Level one safeguarding e-learning as part of their induction. This included a knowledge assessment to determine the understanding of staff upon completion of the module, in which staff must score 70% or higher to pass. Subsequent training at level 1a, level two and level three was provided to some grades of staff dependant on their job role, following the induction process and during the first three months of their employment (probation period). The director of nursing held level four safeguarding training. For compliance rates please see above under mandatory training.

Staff told us if they identified a safeguarding concern, they would raise it with their ward manager and complete an electronic incident report. The incident report was then sent to the patient safety and quality team to decide whether it should be referred to the local authority safeguarding team. However, following our inspection, we requested levels and compliance rates of safeguarding training for all members of the patient safety and quality team. This showed two of the three members of staff in the patient safety and quality team who had responsibility for the initial assessment of incidents had only received online training, which was not a high enough level for their role. This meant patients and residents were exposed to the risk of poor care and treatment, as the staff may not identify incidents that should be referred to the local authority safeguarding team. Following our inspection, the provider revised their training matrix to show these staff should be trained to level three in safeguarding, and that arrangements had been made to ensure these staff received that training.

Following our inspection, we reviewed reported incidents from 26 November 2019 to 5 February 2020 and one incident reported in June 2019. We found three incidents that should have been referred to the local authority safeguarding team and notified to CQC and were not. We had also found this to be a concern during our focused inspection in November 2019. Therefore, we could not be assured that the provider always escalated safeguarding concerns in an adequate and appropriate way.

There was an interim head of patient safety and quality between December 2019 and March 2020, who undertook a review and assessment of the provider's safeguarding processes. As a result of these investigations, the provider began the process of referring historic cases to the local safeguarding team.

We also identified concerns with the hospital's safeguarding vulnerable adults policy dated December 2019, revised on 18 February 2020. The policy did not fully reflect the risks posed to patients and residents by families, carers and friends. The policy did not describe a safe system or outline processes to keep people safe. It did not indicate the responsibility of all staff members to safeguard people. The policy did not reflect the complexities of patients and residents receiving services from the hospital or the issues relating to consent, involvement of families and risks posed through delivery of care or by family members. Failure to have an appropriate, effective safeguarding policy puts patients and residents at risk of poor care and treatment, because staff may follow incorrect safeguarding processes. Following our inspection, the provider told us they were reviewing the policy with input from external stakeholders. The hospital had also commissioned a review of their safeguarding processes by an independent consultant.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

On our last focused inspection, we found infection control practices on Chatsworth ward were not in line with best practice and were placing patients at increased risk of infection. On this inspection, we found this had been addressed. The ward was visibly clean and tidy. The ward had been refurbished in line with best infection control practice, such as easy-to-clean walls which were impact resistant, preventing damage from moving beds around. If walls are damaged it is difficult to clean them effectively. Senior staff conducted a daily walkaround to

check the cleanliness of the ward. Staff were able to locate the cleaning checklist, and we saw this was fully completed by domestic staff. Linen trolleys were stored tidily, and dirty and clean linen was kept separate from each other. This was an improvement since our last inspection.

All other ward areas we visited were visibly clean and tidy. All staff we saw across the hospital were bare below the elbow. Staff had enough personal, protective equipment to care for patients safely, including gloves and aprons, and we saw staff using these. We saw staff washed their hands or used antibacterial hand gel before, during and after caring for patients. We saw staff on Wellesley ward helped patients to clean their hands before mealtimes.

We looked at eight items of equipment across the hospital and saw they were visibly clean and had an 'I am clean' sticker to show when they had last been cleaned. We saw staff cleaning equipment before and after use.

Ward managers carried out monthly hand hygiene audits, as part of the hospital's rotating plan of ward audits. Where a ward's compliance rate was lower than 90%, a weekly hand hygiene audit was carried out until they reached compliance and the ward then reverted back to monthly auditing. We looked at hand hygiene audits from October 2019 and saw 11 of 14 wards had met the compliance target of 90% and above.

The hospital carried out an annual audit on infection prevention and control, using an assessment tool based on quality improvement tools from the Infection Prevention Society. The hospital provided their audit from October 2017 – September 2018 as part of the provider information return. The audit showed all service areas were deemed 'CLEAN' based on the audit tool's standard. We also saw there was a section about infection control on the clinical risk and incident report which was distributed to the risk and incident committee.

There was an infection prevention and control clinical nurse specialist who provided advice and guidance on best practice in the hospital. All new staff received an infection prevention and control orientation and were given a supporting booklet with advice and guidance. Staff received annual infection prevention and control training as part of their mandatory training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

On our last inspection in November 2019, we found the environment and equipment on Chatsworth ward was not always properly used and maintained in line with guidance. Previously, the ward was cluttered and untidy, fire doors had been left open, and staff did not monitor the temperature of patient rooms, despite some patients saying they were cold and being unable to control their own body temperature. On this inspection we found the provider had improved the environment of Chatsworth ward. Staff had removed all rubbish and inappropriate items, and all storage rooms had been tidied. We also saw new alarms had been installed on all fire exit doors, with a sign reminding staff, patients and visitors that the door was for emergency use only. The hospital had introduced temperature monitoring in the patient rooms which were at the end of the building, therefore more likely to be cold. This was a sensor system and was remotely monitored by the information technology (IT) team. An email alert was sent to nursing staff if the temperature fell below 18 degrees Celsius. If a temperature increase was required, staff could request mobile heaters.

Across the wards we visited, waste was disposed of correctly, and disposal facilities were not overfilled. We saw sharps were disposed of and collected by pharmacy.

We looked at resuscitation trollies on Chatsworth and Wolfson wards. We saw the emergency equipment and drugs within the trollies were in date and checked daily and saw records which reflected this. Oxygen cylinders were secured to walls for easy and safe access. We checked four cylinders and they were all in date and safely stored.

Staff told us they had enough equipment to carry out their role, such as hoists. Staff we asked were able to describe steps they would take in the event of broken equipment, including informing the nurse in charge and escalating the problem to the maintenance team who could arrange replacement or repair. There was an on-site wheelchair and postural management team who maintained and repaired patient's wheelchairs. The team also created solutions to give patients tools to communicate and be independently mobile.

There were arrangements for equipment to be serviced by the estates team. There was an emergency generator which could be used in the event of power failure. The response to this or any other major equipment failure was outlined in the hospital's major incident policy.

In 2016 the hospital launched a refurbishment programme which included non-clinical areas such as the modernisation of the reception, kitchens, restaurant and on-site staff accommodation. This also included a five-year ward refurbishment programme. On Drapers ward we saw the environment, which had been recently refurbished, was modern and in line with best practice. For example, we saw there was a bespoke bedside hoist for each patient, which was innovative practice. The hospital had also opened a refurbished therapy hub, with a separate quiet gym, sensory room, clinical and therapy spaces. The hospital had refurbished Haberdasher House, a separate building in the grounds, as a dedicated young person's unit. Further ward refurbishments were set to be completed by May 2020, and the hospital planned to complete all ward refurbishments by 2022/23.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, we found handover processes on Chatsworth ward were not fully effective.

Staff carried out risk assessments for each patient in line with national guidance. Staff managed risks to patients through their care plans which were updated every three months or in light of any new risks to patients. For example, this included assessments to identify any risks associated with skin integrity, moving and handling, eating and drinking, swallowing and falls. For patients who were able to mobilise independently and were at risk of falls, staff could access sensor mats so that staff could be made aware that the patient had got out of bed.

We asked three staff to talk us through patient care plans, and all were able to tell us about specific risks relating to that patient's condition, for example the risk of rapid desaturation or the need for particular equipment to prevent pressure ulcers. In patient records we saw staff could access care plan summaries which captured key areas of risk and support patients needed in a targeted guide for staff.

Staff identified and responded appropriately where patient's health deteriorated or in medical emergencies. There were call bells fitted in every ward we visited, and we saw staff responding promptly to these. Staff could seek support from senior staff via the bleep holder or doctors on call. All staff we asked were aware of the arrangements, both in and out of hours, should a patient deteriorate. There was a nurse site manager whom staff could escalate to through a bleep, and staff told us they would also inform the duty doctor out of hours. Staff told us if the patient required transfer to the local acute hospital, the duty doctor would write a medical transfer letter.

On some wards, staff updated patients National Early Warning Scores (NEWS2) electronically. On this electronic system NEWS2 scores were automatically calculated from patient's observations to alert staff if a patient was scoring a higher NEWS2 score than normal. On other wards, staff calculated NEWS2 scores manually. Some patients had their NEWS2 score modified because of their condition. Where NEWS2 scores were entered electronically, doctors were able to pick this information up immediately, and request investigations such as blood tests in response

Staff told us they combined patients' NEWS2 score, with their clinical judgement, for example based on the patient's physical appearance. Staff checked patients' observations at a standard frequency of 12 hours, which were increased should the patient display any signs of deterioration, such as vomiting. Staff were able to give examples of situations in which patients might be at particular risk of deteriorating, such as if a patient was going through the process of weaning from a tracheostomy.

Staff recognised risks to patients from behaviour that challenged and could seek support from senior staff in these situations. Most staff across the hospital had received or were planned to undertake Prevention and Management of Violence and Aggression (PMVA) level one training. On the specialist services wards, all staff had received PMVA level one, and agency staff were required to complete this training before being booked onto shifts

on these wards. A group of staff had formed a working party, whereby some staff would receive PMVA level two training as 'ward champions' and would then share the learning amongst colleagues. Where patients displayed challenging or aggressive behaviour, staff completed a chart to record behavioural concerns. These charts provided data to support a referral to the hospital psychology services. The data was submitted to clinical psychologists and therapists who then held meetings with staff to provide advice on how to manage the patient's behaviour and keep them safe. We also saw 'top tip' leaflets on understanding challenging behaviour and de-escalating behaviour had been shared with all staff in December 2019 and added to patient bedside folders.

On our last inspection, in November 2019 we found handover processes on Chatsworth ward were not fully effective. We found there was no handover sheet given, some staff wrote notes, but others did not, and some staff arrived midway through or were required to attend to patients during the handover. Therefore, there was a risk that they could miss key information relating to patient care. On this inspection we observed morning handovers on both areas of Chatsworth, and evening handovers in the day room of Chatsworth and on Hunter ward. Both Chatsworth and Hunter are continuing care wards where permanent staff often care for the same patients over a long period of time. On Chatsworth, we found our concerns regarding the Chatsworth handovers remained the same. No handover sheet was given. Some staff took notes in their own notebooks, but others did not, and one member of agency staff wrote some notes from the handover on a paper napkin. A number of staff members arrived when the handover had already started, and some left the room and later returned during the handover. This made the handover difficult to follow. By contrast, the evening handover on Hunter ward we observed was effective and focused. There was a handover sheet with all patients' medical conditions, and whether there was a do not attempt cardio pulmonary resuscitation plan in place. All staff remained in the room from start to finish and engaged with the handover throughout the discussions. Each nurse responsible for their group of patients was able to provide standardised feedback on their care and treatment. We were concerned that the effectiveness of handovers varied between Chatsworth and Hunter wards.

Following our inspection, the provider told us it was not normal practice for staff to leave a handover meeting until it had ended, unless there was a patient care issue that needed to be immediately attended to. The provider added that staff who missed any information would be updated immediately after the handover was completed.

Nurse staffing

The service mostly had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The hospital provided us with information which showed they used the updated National Quality Board Safe Staffing guidance and expectations for nursing staffing across the hospital and used the Safer Nursing Care Tool as a framework to decide on staffing numbers. Within the brain injury service, staff told us they aimed to comply with British Society of Rehabilitation Medicine (BSRM) guidelines in nurse staffing ratios and reported on compliance internally and to external commissioners

The hospital provided us with information which showed there were 22 vacancies for registered nurses, out of an establishment of 137, giving a vacancy rate of 16%. However, these posts were recently recruited to through a successful overseas recruitment drive and retention of student nurses. Most wards were imminently due to have a full complement of staff once all new recruits had received their nursing registration. The hospital used agency staff or its own staff bank to cover shortfalls.

Nurse to patient ratios varied depending on the needs of the patients on each ward. On Jack Emerson Centre (ventilator unit) the patient to nurse ratio was 3:1. This same ratio was maintained across the hospital for any patients who had a tracheostomy.

On our last inspection in November 2019, some staff on Chatsworth ward told us they felt "rushed off their feet" and sometimes struggled to cope when the ward was busy. On this inspection, we found this had improved. The hospital had changed the staffing arrangements for Chatsworth ward, so that staff were allocated to care for patients on the same part of the ward. Previously, staff

had been allocated to specific patients, who may have been in different areas of the ward. Leaders had also introduced a team leader healthcare assistant and floater roles. Staff in these roles supported their colleagues and ensured they took their breaks. Staff also now worked long days (12 hour shifts) allowing more time for breaks and to complete documentation. All staff we spoke with on Chatsworth commented positively about these changes and told us the effectiveness of staffing and team working on the ward had improved. Staff also commented they had received positive feedback from relatives about the new staffing arrangements as it had meant better continuity of care for their relative.

Across the other wards in the hospital, staff told us the numbers of staff on shift mostly matched the planned numbers of staff. A small number of staff told us they sometimes felt overwhelmed with the volume and complexity of care and treatment they needed to provide to patients. Staff told us this was particularly the case during night shifts such as completing medication rounds, making sure patients were turned and completing documentation. However, following our inspection the provider told us staffing in the hospital was in line with NHS safer staffing levels. If short term shortages were identified, the two night managers stepped in to provide support, and staffing was flexed across wards.

Bank and agency staff received a corporate induction to the hospital and then a local induction to their area of work. Senior nursing staff told us that agency staff were always paired with a permanent member of staff. Agency staff we spoke with were able to tell us where they would locate a patient's care plan.

The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The provider told us therapy staffing levels were aligned to meet the needs of the patients and residents in each service area. Therefore, staffing in the brain injury service was increased to meet the needs of patients who are undergoing level one rehabilitation. The hospital also used BSRM guidelines to benchmark and review allied health professional staffing, in line with patient complexity scores.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The provider told us that during regular working hours there were 3.4 whole time equivalent (WTE) GPs present, often with a senior GP from the Wandsworth Medical Centre (the practice providers for the hospital). GPs provided care for patients in the continuing care wards. There were 4.2 WTE rehabilitation consultants, with at least one consultant on site from 9am to 5pm Monday to Friday. The provider told us often all consultants were present. One of the rehabilitation consultants was also contractually responsible for providing specialist support to all GPs. There were seven visiting consultants who had expertise in different specialisms such as palliative care, respiratory, neuro-psychiatry, urology and Huntingdon's disease.

Out of hours, there was a consultant in rehabilitation and a junior doctor on call. The junior doctor on call reported to the consultant on call as required.

We spoke with junior medical staff at the Jack Emerson centre, who told us the medical cover for the centre was adequate, and they divided the patients' care equally between them. Junior doctors told us that they received inductions when they took up the role. They were given a tour of the hospital and shown how the systems worked. Medical staff were taught by physiotherapists to carry out physiotherapy care to ensure patients were always cared for in line with tailored manual handling guidelines. Two consultants from a local teaching hospital did ward rounds on the Jack Emerson Unit every other Wednesday. They gave advice on the treatment and management of ventilated patients. Medical staff told us cover and handover arrangements were adequate and there was good communication between medical staff.

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all repositioning charts were up to date on Chatsworth ward.

Requires improvement

Long term conditions

Through our engagement with the provider and our inspection, we noted that the hospital was currently in the process of transferring to an entirely electronic system. The hospital had held documentation launch days whereby staff could drop in and ask questions about changes to documentation.

All care plans we looked at across the hospital were complete and up to date. Care plans were reviewed every three months or sooner if a patient's needs changed. We saw care plans were individual to each person. We found care plans reflected people's support needs and included ways in which staff could support people in their identified areas of support.

The hospital health records policy outlined that an audit of patient records should be conducted on an annual basis. In areas where improvements were required, audits were increased, in accordance with the records audit tool action plan. Staff also conducted monthly checks on documentation as part of the monthly rotating programme of ward audits. We viewed results for this from week commencing 21 October 2019 which showed 9 of 13 wards participated and results ranged from 73 to 100%, with 6 wards achieving a score of 90% and above.

We looked at 12 sets of intentional rounding charts and repositioning charts across Hunter, Glyn, Andrew Reed, Coombs, Wolfson and Wellesley wards. Intentional rounding charts were completed every two hours, and involved staff checking whether patients were safe and comfortable, and all their needs were being met. Repositioning charts were completed to show when patients had been turned and were sat in their wheelchair or lying in bed, in line with their skin integrity assessment. We found all sets of these charts which we looked at were well organised. Ten sets were fully complete and up to date, two were partially complete, although explanations were recorded as to why.

On our last inspection, we saw record keeping was poor on Chatsworth ward, with intentional rounding charts being incomplete in all eight patient records we reviewed, for one or more days. On this inspection, we looked at seven bedside folders which contained intentional rounding and repositioning charts, and accompanying care plans. Completion of intentional rounding charts had improved compared to our last inspection, with fewer gaps. However, on our inspection on 10 February 2020, we looked at 16 repositioning charts for three patients, across a sample of dates from 28 January 2020 to 10 February 2020, and found all of the repositioning charts we looked at were incomplete. This meant turning was inconsistently recorded, and there was a risk of patients and residents not having their care needs met, particularly by new or temporary staff who were not familiar with the patient. However, following our inspection, the provider told us they identified four repositioning charts which were not completed for one patient on one night on Chatsworth ward, and these were identified the following morning and addressed immediately.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The medical director was the Controlled Drugs Accountable Officer, and the lead for the safe and secure handling of medicines was the senior pharmacist. The senior pharmacist reported to the medical director as the board member accountable for pharmacy services. The medical director chaired the medicines management committee including drugs and therapeutics committee, which fed up to the board through the patient safety and quality committee.

Staff told us they were supported by pharmacists, who visited the wards on a weekly basis to audit medicines supply, storage and records. Pharmacists visited the continuing care wards every week to reconcile repeat prescription slips against medicines administration charts (MAR) and highlight any inaccuracies so staff could rectify them.

The senior pharmacist told us medicines for wards in the specialist services and brain injury service were dispensed by the on-site pharmacy. Medicines for residents in the continuing care wards were prescribed by GPs and dispensed off site at a community pharmacy.

At the time of our inspection, wards in the brain injury service and specialist services used electronic prescribing and medication charts, whereas continuing care wards were still using paper medicines administration charts for the time being. The hospital was working towards all wards using electronic records for medicines.

We looked at 11 medicines administration charts on the continuing care wards and found these were fully

complete. Staff told us they checked for missing signatures on medicines administration charts at the end of each shift, and they would report any missing signatures as an incident. If a dose was missed, staff told us they could contact the ward GP who would attend to review the patient and advise if the dose could still be given.

We looked at nine electronic medication administration charts on Drapers ward and found these were mostly complete. Staff told us there were some issues with the electronic system, such as the system not recording when a patient had been admitted to an acute hospital, and therefore their medication administration record charts showing missed doses.

Many patients on the continuing care wards received their medicines through a percutaneous endoscopic gastrostomy (PEG) tube. Staff told us this meant they needed to crush some medicines, but on Glyn ward they only had one crusher for all patients and would clean the crusher in-between patients with a paper towel. We clarified this with the senior pharmacist who confirmed that each patient did in fact have their own crusher and they would rectify this issue.

We visited five clinical rooms, on Glyn, Drapers, Wolfson and Chatsworth wards. We saw the clinical rooms were locked, with either a swipe card or keys held by the nurse in charge. Medicines were stored securely in locked cabinets. On the Jack Emerson Centre medication fridge and room temperatures were monitored remotely which was good practice. This was a pilot at the centre and staff told us was likely to be rolled out across the hospital in due course.

Controlled drugs stock was checked each day by two registered nurses, and we saw records which reflected this. We looked at a sample of controlled drugs stock and these were all in date. Staff told us that any medicines that needed to be disposed of were returned to the on-site pharmacy.

Across the wards we visited, we saw staff wore 'do not disturb' aprons when completing drug rounds.

In the event of a medicine related error, staff were required to fill out a medication error reflection form. This included a description of the incident, potential risks to the patient, related national or local guidelines, contributing factors, and an opportunity for staff to ask for support from their manager or comment whether there was wider learning needed across the hospital. This was good practice.

The hospital had introduced an intravenous antibiotics pathway, which started in July 2019. Chest, urinary tract and skin infections were common amongst patients at the hospital, and the aim of the pathway was to prevent admissions to acute hospital, which could be difficult and disruptive for patients with cognitive and physical disabilities. We viewed data which showed from October 2019 to January 2020, seven patients received intravenous antibiotic treatment at the hospital without needing an acute admission. The provider told us the aim was to have all wards administering intravenous antibiotics by June 2020. The hospital had taken account National of Institute for Health and Care Excellence guidelines on antimicrobial stewardship in their policy on antibiotic prescribing. The hospital had access to a consultant microbiologist who could provide advice.

Incidents

The service did not consistently manage patient safety incidents well. Staff reported incidents and near misses but did not always recognise when a safeguarding referral was required. The head of nursing had initiated a system to share lessons learned with the whole team and the wider service, but this was not yet fully embedded.

We viewed the incident reporting and serious incident policy, dated 11 December 2019. We were concerned that the policy lacked detail that would offer assurance around incident reporting and due diligence in responding to incidents.

The policy referenced criteria for when the serious incident procedure should be implemented. However, the policy did not outline the process for oversight and review of serious incidents which were not initially recorded as such, other than by the patient safety and quality team. There was no process for oversight of decision-making around categorisation of incidents and the reporting to CQC through statutory notifications. Although there was mention of learning activities in the policy, it was unclear in the policy who was responsible for these either for delivery or the content of the learning or how it would be shared across the hospital. The lack of

clear and effective governance processes around incidents meant there was a risk that staff could miss opportunities to keep patients safe and learn from incidents. The hospital was in the process of embedding some new learning initiatives, as described below. Following our inspection, the provider told us they planned to review the policy in collaboration with external stakeholders.

Despite this, there were some initiatives to improve learning from incidents, instigated by the head of nursing who joined the service in September 2019. The head of nursing told us this shared learning should take place at handovers on a weekly basis. Following our inspection, the provided told us this took place using a standardised template which was then discussed at the 'stand-up' operational meeting on a Monday morning. During the two evening handovers we attended, staff discussed shared learning from a recent incident and were required to sign a document to show they had received and understood the shared learning. Learning from incidents was displayed as part of a 'shared learning' board on the ward which summarised the incident, what should have happened, what staff would do differently next time, and what they had learned. The head of nursing also told us of plans to use this 'shared learning' board as part of twice daily 10 minute 'Putney Gatherings' which would cover a standard agenda of incidents, improvement projects and celebrating successes. Staff were in the process of rolling out 'Putney Gatherings' to all wards at the time of our inspection. Following our inspection, the provider told us that prior to this initiative, there was a system of multi-disciplinary forums which reviewed in depth cases (serious incidents and non-reportable root cause analysis investigations). The provider told us that incident reporting culture was high amongst staff.

Following our inspection, the provider told us incidents were overseen and reviewed by the patient safety and quality team, and relevant department heads. Incidents were also reviewed daily by executive leaders, managerial nursing staff. We saw incidents were discussed and reviewed at committees such as the board medical and patient safety and quality committee. We noted in minutes of executive meetings that there were plans for the implications and learning from incidents to be considered at board away days.

Incident investigations were not always managed in a timely way. The incident policy stated that incident investigations and records closure should occur no more than 4 weeks after the incident was raised. We looked at all incidents reported at the hospital from 26 November 2019 until 5 February 2020. We found that in a small proportion of incidents (17 of 452), the timescales for investigating and reporting on had not been met. We found 17 incidents that had occurred in November and December 2019 where the severity of the harm caused by the incident had not been determined because there was no recorded outcome of the investigation. The approval status for 17 incidents was either awaiting local or medical review or awaiting sign off by the head of service or patient safety and quality team. Following our inspection, the provider told us this meant that an investigation had occurred but had not yet been signed off. The policy stated that the patient safety and quality team reviewed the timeframes of open incidents by ward, on a two-weekly basis to provide oversight. However, we were concerned that incident reporting policy did not contain enough detail on how actions on delayed incident investigations would be overseen through the hospital governance structure. Therefore, there was a risk that the mechanisms to review incidents which had not had a completed and signed off investigation were not sufficiently robust.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of healthcare providers to notify patients of and provide reasonable support when something went wrong, even if someone was not harmed. Staff we spoke to could explain the duty of candour and gave examples of when they had activated the duty of candour in an incident of no harm. We also saw an example of where the hospital had translated a duty of candour letter in to another language to ensure it was accessible.

Leaders reported all patient deaths, including those that occurred within 28 days of discharge from the hospital, to the regular mortality review committee. Reports and minutes of this committee shared with the deceased patient's relatives under the duty of candour. The provider told us where appropriate actions and learning from the committee would be discussed at nurses'

forums, team meetings and doctors education sessions. The hospital planned to include learning from the mortality review committee in to the new 'Putney Gatherings' once rolled out.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

The hospital performed well in the safety thermometer. In August, September and October 2019, the hospital overall showed a percentage of 99% harm free care, which was better than the national overall percentage of all submissions to the safety thermometer in those months of just over 93%. Safety thermometer results were shown in the patient safety and quality report which fed up through the hospital's governance structure to the board.

We saw safety thermometer results were displayed on the wards we visited for patients, their relatives and visitors to see. On some wards, such as Drapers and Devonshire, staff discussed safety thermometer results during handovers.

Are long term conditions services effective?

(for example, treatment is effective)

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including National Institute for Health and Care Excellence and other expert professional bodies, to achieve effective outcomes. For example, we saw staff used national standards in respiratory management to monitor patients and provide enhanced care to meet their needs. All patients in the brain injury service were assessed by a consultant in rehabilitation medicine in line with national guidance. Staff worked together to organise pathways for patients. For example, the internal transfer pathway was outlined in the hospital's admission policy and included multidisciplinary handovers and assessments covering a patient's care and treatment needs.

There were seven clinical nurse specialists in post for a number of clinical specialties including tracheostomy, infection prevention and control, continence, and end of life care. The clinical nurse specialists provided support and training at ward level. Staff were aware of how to contact them. Clinical nurse specialists attended wards regularly to ensure staff were following guidance. Allied health professionals also wrote and monitored tailored guidance on moving and handling and positioning for specific patients.

The hospital also provided advice and information on evidence-based care and treatment to wider stakeholders through educational events. For example, the hospital ran a national course on the multidisciplinary approach to caring for patients with Huntington's disease. The assistive technologies team were involved in the West London national hub for communication aids, and offered support to local students completing master's degrees, as there were links to the treatment of sports injuries as well as neuro-rehabilitation.

The hospital had developed The Putney Prolonged Disorder of Consciousness Toolkit, which was a set of resources to support the assessment and monitoring of patients in a prolonged disorders of consciousness (PDOC). The toolkit was informed by the Royal College of Physicians national clinical guidelines on prolonged disorders of consciousness. The toolkit was shared with clinicians via the hospital's website. On Devonshire ward, a controlled sensory environment had been introduced. This was based on research by the lead consultant showing patients with prolonged disorders of consciousness were unable to manage having more than one sense stimulated at any one time. The controlled sensory environment involved an activity schedule that enabled or addressed only one sense at a time.

Long term conditions

The hospital had a Withdrawal of Clinically Assisted Nutrition and Hydration (in patients in a prolonged disorder of consciousness (PDOC)) and an End of Life Care policy. We saw these policies were based on national evidence-based guidance and standards, including from the Royal College of Physicians and Association of Palliative Medicine. The hospital had also involved palliative clinicians from local NHS trusts in the review of these policies.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Each patient had a personalised meal mat with guidance for staff on ensuring the patient received enough food and drink to meet their needs and improve their health. We viewed meal mats which included detailed information including positioning of the patient during mealtimes, level of help they needed, communication, swallowing strategies, and food texture. Specific staff on each ward acted as leads during mealtimes, to ensure all staff were complying with the meal mat guidance and assisting patients to eat safely. Mealtime leads attended a full day training course and had their competencies assessed and signed off by a speech and language therapist and occupational therapist. Every ward received annual meal time refresher training, accompanied by an e-learning programme which was accessible to agency staff.

Speech and language therapists and dietitians provided advice and support for nutrition and hydration and risks of dysphagia (difficulty swallowing). Speech and language therapists reviewed all patients receiving care on the continuing care wards annually to ensure the guidelines for eating and drinking were still appropriate. Patients had a target weight and their current weight recorded on their care plan, and staff assessed patients for their risk of malnutrition every three months in line with scheduled care plan reviews.

We observed three mealtimes on different wards across the hospital. On some wards, there were protected mealtimes. On other wards patients had individual choice as to when they ate. During mealtimes, all staff wore aprons and patients were provided with clothing protection if needed.

Some patients who were able to communicate could choose to receive nutrition and hydration by a percutaneous endoscopic gastrostomy (PEG) rather than orally if they preferred. Staff told us in this case a dietitian and speech and language therapists would discuss advantages, disadvantages and risks with the patient and empower the patient to decide what they wanted to do. The therapists would then complete a future feeding plan and send it to the patient's GP.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

For patients who were able to verbally report their pain, staff used a 1-10 pain scale, which was part of the NEWS assessment.

Some patients were prescribed pain relief to be administered as needed. We asked two staff how they would know if patients needed pain relief and they told us they knew their patients well so they could tell when they were in pain and would look for physical changes such as grimace.

When patients were not able to communicate, pain was assessed from movement or facial expression. Staff used the Visual Analogue Scale (VAS) pain score to review levels of pain. This measuring tool assessed subjective characteristics that could not be directly measured. For example, the nurse said they would look for patients frowning, wincing or guarding painful limbs. These kinds of behaviour indicated people needed their prescribed pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Long term conditions

Across the brain injury service, we saw staff had designed a method of goal setting whereby patient values were put at the centre of any goal setting exercise. A multidisciplinary team (MDT) assessed the patient's ability to contribute to goal setting, which involved looking at their ability to communicate, level of support needed and capacity to make decisions. Patients and their families were involved in the completion of a values checklist, that was unique to the hospital, to share with staff what was most important to them prior to their injury. The information from this checklist was then used to develop patient goals. We saw how these goals were planned by the MDT team, by breaking them down into steps leading up to achieving the overall goal. For example, 'to eat and drink as I did before' included 'to use a knife and fork to eat my meals' and 'to increase quantity of oral fluid intake and initiate asking for drinks'. We saw patient goals were embedded in to all documentation used in multidisciplinary case reviews. Staff reviewed patient goals every four weeks. There were plans for adherence to the goal setting pathway to be audited, and staff told us they had presented their ideas to the audit committee. Staff involved in developing this goal setting initiative were due to present their findings at two national conferences.

The hospital provided us with a copy of their clinical audit plan for 2019. This included audits on NEWS, Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR), meal mats, compliance with speech and language guidelines, tracheostomy care, goal setting in the brain injury service, gastrostomy care, and the effectiveness of the tone clinic. Staff were able to give examples of where they had used audit findings to make improvements. For example, In April 2019 an audit was undertaken by the SALT team regarding suitable equipment at mealtimes across six wards in the hospital. The audit found staff were not always using the correct equipment, so actions were taken to share learning across the hospital. As a result, this compliance with equipment guidelines improved from 80% to 97%.

On Drapers and Devonshire wards, local audit results were displayed on the ward such as documentation and hand hygiene. Where there was lower compliance, they also included action plans. Staff could give examples of shared learning from audits.

The hospital had received accreditation in Communication Access accreditation, and Independent Neuro-rehabilitation Providers Association Achieved Peer Assessed Accreditation against set rehabilitation standards.

Staff told us the hospital contributed data to the UK Rehabilitation Outcomes Collaborative. The hospital received quarterly benchmarking information data from this on the performance of their rehabilitation services. For individual patients, staff used standardised scales to measure outcomes such as St Andrews Swansea Neuro-behavioural outcome scale, and the Hospital Anxiety and Depression Scale.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The hospital provided us with data which showed 100% of staff of all disciplines had received an appraisal in the period from December 2018 to December 2019. The provider also provided evidence that they had checked the professional registration for all relevant staff. Staff told us appraisals were linked to the hospital values and encouraged them to identify areas of success and improvement. Medical staff who were directly employed by the hospital received an appraisal. Other medical staff such as visiting consultants received appraisals from their resident NHS trust.

We viewed examples of agenda templates for one to one meetings for matrons with their head of nursing. This included questions which encouraged matrons to reflect on training needs for themselves and their teams, what they were proud of and concerned about, learning from incidents and audits, and specific local clinical subjects such as compliance with mandatory training and documentation.

Allied health professionals told us they had monthly supervision meetings and could participate in monthly forums for their disciplines.

The hospital encouraged staff to develop their skills. For example, we saw the hospital had supported a physiotherapist to qualify as a non-medical prescriber. The hospital had also created bespoke programmes for

nurses and healthcare assistants (HCAs) called the Putney Nurse and Putney HCA. These were reflective five-day programmes, aimed to enhance staff's understanding of the care of patients and their families who experienced complex, enduring and challenging neuro-disability, as well as the care of patients on rehabilitative pathways. The course was also open to external candidates. Many nurses and healthcare assistants we spoke with commented positively on the programme and how it increased their confidence. The director of nursing expressed an ambition for the Putney programmes to be expanded to include other roles such as ward administrators, and to make the Putney programmes compulsory.

There were initiatives to facilitate career progression for staff. For example, the hospital had recently regraded ward administrator roles, to recognise the value of their role and to give staff the option to progress to senior ward administrator. The executive team also told us of plans to support domestic staff to complete the care certificate and progress to a nursing associate role.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

In the brain injury and specialist services, there was a large ward-based MDT team of allied health professionals, and nursing staff divided into four consultant-led teams. Each patient had a multidisciplinary weekly case review. For example, in the Jack Emerson Centre, every Monday the multidisciplinary team of nurses, therapists and medical staff looked at all aspects of patient care. Staff involved family members and patients in these discussions where patients were able to communicate. There were also regular formulation meetings where multidisciplinary staff could discuss any patients they were concerned about.

Formal multidisciplinary discussions were less frequent for patients receiving care on the continuing care wards but were usually conducted on an annual basis. Therefore, multidisciplinary meetings were scheduled every two weeks to ensure all patients were discussed over the year. However, staff were clear that multidisciplinary meetings could be arranged quickly at any time if there were concerns or changes to discuss.

Across the hospital, staff commented positively on multidisciplinary working and told us different disciplines worked well together without hierarchy. Many nursing staff told us they saw allied health professionals on the wards every day. Multidisciplinary staff also occasionally attended nursing handovers. On Drapers ward, therapists covered the ward once per month to release nursing staff for training.

Seven-day services

Key services were available seven days a week to support timely patient care.

The hospital provided patients with 24 hour care, seven days a week.

A respiratory physiotherapist was provided on Friday and Sunday on bank holiday weekends for any patient or resident needing support. Aside from this, there were limited therapy services at the weekend. In the hospital's strategy, there was reference to increasing access to therapeutic and leisure activities seven days a week.

Any admissions out of hours were managed in collaboration with the on-call doctor and on-call manager.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The hospital had a 'Carers' Corner' where families, patients and residents could meet, and access information about hospital events. Throughout the hospital, there were leaflets available on conditions treated by the hospital and details of local support agencies. Leisure and family services also arranged regular presentations from guest speakers on legal or welfare related topics.

The hospital also offered a series of free open lectures on topics relevant to the care of patients at the hospital. For example, we saw recent lectures had included informal question and answer sessions with the nursing team and the importance of sleep and recovery from brain injury.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed

national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff conducted capacity assessments for patients; these occurred on admission. Where people lacked the capacity to make a decision about their placement, best interests decisions were made regarding their placement. Where people were deprived of their liberty and they were unable to consent to this, the hospital submitted Deprivation of Liberty Safeguards (DoLS) applications to the local authority, in line with the Mental Capacity Act.

Mental Capacity Act (MCA) care plans were in place in all records we looked at. These care plans were authorised by senior staff. We saw all care plans we looked at clearly recorded whether people had the capacity to consent to their care. Where people did not have the capacity to consent, we saw evidence that best interests decisions had been made in multidisciplinary meetings. Where there were restrictive measures in place such as wheelchair belts or bedside rails a DoLS application had been submitted.

Staff recognised patient capacity to make decisions could fluctuate, and they understood their responsibility to assist patients to make and communicate their own decisions as much as possible. For example, we saw staff carefully observing non-verbal response from patients about which activities they would like to participate in, or food choices.

Across the hospital, there were some patients who were awaiting a DoLS approval or assessment from the local authority. Staff told us not all local authorities approved DoLS as there were delays and backlogs at the local authority. We saw where DoLS had expired staff submitted applications to renew them. The ward manager told us the guidance from the local authority DoLS team was to continue to manage people according to the previous DoLS, best interests discussions, and least restrictive practises. For example, in the Jack Emerson Centre, patients who previously wore mittens to prevent them from hurting themselves, had been able to have the mittens removed as a result of one to one care.

MCA/DoLS information, such as whether a DoLS was in place, when it was due to expire, and any conditions were recorded on a custom-built electronic system. The current system was overseen by an MCA/DoLS lead clinician, who sent a monthly report with the latest status of any DoLS authorisations to all the ward managers and audited the system regularly.

Information guides regarding MCA/DoLS were on display on the wards. Staff were aware of the MCA and how they would get consent from people in line with this. One staff member said, "We make decision in patients' best interests. If they cannot consent, we speak to family, and other staff. I would never make a decision by myself." Some patients communicated using eye gaze technology so were able to give consent through this.

Are long term conditions services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed that staff treated people with respect and provided person-centred care. For example, we saw that most staff interacted with patients and relatives in a friendly and patient manner, taking time to engage in conversation with them.

Where patient bays or rooms were shared, staff used curtain dividers to protect a patient's privacy. We saw staff closed doors and curtains whilst providing personal care, to preserve a patient's dignity.

Most relatives we spoke with were positive about the care their relative received at the hospital. For example, relatives told us their relative was "well looked after, happy on the ward", staff knew them well, and all their needs were understood and met. Relatives also told us the hospital was "wonderful", their relative's care had been "professional and consistent, but also kind", and that staff had paid "great attention" to who their relative was as an individual. Another relative said "I cannot find the words to praise this place enough." A patient also told us that "the attention paid by staff is brilliant…they treat people as individuals".

Requires improvement

Long term conditions

We spoke with three patients. One patient told us the hospital provided "by far the best" care they had experienced, and "hospital spends a lot of time to continually improve this place." Patients valued their relationships with staff. One patient told us they enjoyed a "lot of laughing" with staff.

However, we observed a difference between the way agency, permanent and bank staff supported patients during mealtimes. We saw permanent and bank staff kept patients informed with what they were doing and offered them choices. We saw permanent and bank staff chatting to patients, explaining what food they had, and communicating in a kind engaging manner. We observed some agency staff did not interact or engage with patients during mealtimes.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff we spoke with recognised the emotional impact patients care, treatment and condition would have on themselves and their loved ones. For example, one staff member told us that some patients experienced a narrowing of their social network, so it was important that staff and volunteers spent time with patients as people. Staff told us that some residents did not have regular visitors, so they fostered a family-like atmosphere, for example by celebrating each resident's birthday.

The hospital chaplain had multifaceted roles in the organisation and offered pastoral care to all patients and their relatives. The chaplain worked with relatives to discuss their 'ambiguous' loss; a loss that occurs without closure or clear understanding. For example, whilst the patient was physically present, they were not who they were before the onset of their brain injury or neuro-disability. Many relatives and patients told us how much they valued the support of the chaplain. The hospital held an annual service of thanksgiving to commemorate and remember those who died in the previous year.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Throughout our inspection, patients, relatives and staff told us staff at the hospital took the time to get to know their patients well and had built understanding relationships with them over time. Patients' relatives told us they were involved in care plan development for their relatives.

Staff told us they always tried to put themselves "in the patient's shoes" and that they cared for them "like I am looking after my family". This was an approach championed by the director of nursing who told us they were keen to offer patients and residents a good quality of life. Staff took steps to maximise patients' independence. For example, during a music therapy session we saw staff gave patients choice and control as to how they wanted to participate. Staff gently encouraged contributions by offering patients to take on the role of director in the music session.

Many patients were unable to communicate or were only able to communicate through non-verbal cues such as blinking. We observed staff showed patience and understanding when interacting with these patients. Staff demonstrated to the patient that they had their full attention, for example by making eye contact, sitting at the same level as the patient's wheelchair or holding their hand to reassure them.

Patients we spoke with in the brain injury service told us they were aware of what they were working towards in terms of their rehabilitation goals, and they had been given the opportunity to input into their goals. Patients told us they felt supported by staff to achieve these.

Staff we spoke with, including volunteers, told us there could be occasions where a relative's wishes could be in conflict with medical or therapeutic advice. Staff told us they tried to make sure patients' relatives felt listened to, whilst also managing expectations. For example, staff showed families how a change in care and treatment would work, rather than just telling them. The patient experience lead offered face to face meetings in the first instance if relatives had concerns.

In the brain injury and specialist services, patients were allocated a key worker who acted as first point of contact for family members who had any concerns or questions.

Requires improvement

Long term conditions

A small number of relatives we spoke with told us they did not always feel listened to by staff and issues they had raised had not been addressed. One relative commented that they felt staff were always rushing.

Are long term conditions services responsive to people's needs?
(for example, to feedback?)

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

We were told of plans to develop the hospital services to align with the changing conditions of some patient groups. For example, there were long patient stays on the ventilator unit and subsequently a waiting list of around 18 months for admission. There were plans to increase the capacity of the ventilator unit and number of tracheostomy beds elsewhere in the hospital.

The hospital held contractual meetings with commissioners to discuss current contracts and any future developments. Commissioners completed quality assurance visits to the hospital throughout the year and whenever needed.

There was a comprehensive programme of activities available for patients and relatives to engage in. There was a timetable of weekly activities on each ward, for example, music therapy, film nights or karaoke, which was run by a committed activities team, including allied health professionals and volunteers. Each ward had a dedicated activities and leisure co-ordinator, and we saw their name, photograph and contact details were displayed on the ward. The hospital was set in attractive grounds and volunteers or family members were able to take patients outside to enjoy the gardens.

The hospital provided a service whereby families could borrow an accessible vehicle to take their relative out for the day, subject to a risk assessment by the multidisciplinary team. There was no charge for this service, only the cost of fuel. The vehicle was also used by staff to take patients on day trips home. This was responsive practice. There was also accommodation available on site for families to use.

Staff told us how they had supported patients with practical steps to register to vote in the recent general election, facilitated impartial access to information about the candidates, and postal or in-person voting.

There was an end of life care committee which provided advice and support on advanced care planning.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

We saw many examples of responsive practice from staff to meet patient's individual needs and provide holistic care. We observed that a member of staff had arranged for musicians to attend the ward to perform for a particular resident on a continuing care ward, who had been unable to attend the chapel service where the musicians had recently been playing. We observed staff had created innovative ways of meeting patient's sensory needs, for example with specially designed clothing.

Staff often went the extra mile to facilitate individual patients access to leisure and activities that were of personal importance to them. For example, on one ward, staff booked a room and sourced toys once a week, so that a patient could play with their children. Some ventilated patients had day trips home and they would be accompanied by a nurse and healthcare assistant who knew the patient well. The hospital also organised trips out, tailored to patient's particular wishes. For example, we saw staff had organised trips to the theatre, football matches and visits to London landmarks.

People's diversity was respected. Families and patient boards included details of chaplaincy services that were available. There was provision for people to practice and take part in religious activities.

Ward administrators were responsible for meal orders. Ward administrators we spoke with told us they worked with families and patients regarding menu choices to ensure patients and residents got the meals they liked. A

ward administrator we spoke with gave an example of a resident who was a pescatarian and how they ensured additional choice was made available for the patient when needed. There was a three week rolling menu which was changed twice a year. This included access to religious and cultural meal choices such as halal, kosher and afro-Caribbean meals. We saw where relevant staff gave patients a choice of food and where they wanted to eat.

On some wards there was a communication book which patients and relatives could use to leave messages for staff, for example requests for their relative to go to specific activities or informing staff about their relatives preferred food.

The hospital had launched a charitable initiative for patients without relatives, which included funding to provide essentials such as toiletries and clothes.

Most patients had a communication passport to advise staff how to interact with them. This also travelled with the patient should they attend an external medical appointment or have to be admitted to an acute hospital for treatment. All patient care plans also contained reference to their likes and dislikes.

If patients or their relatives did not speak English, face to face interpreters were arranged. We saw the hospital arranged for important documents, such as duty of candour letters, to be translated if necessary. If interpreters were difficult to arrange, due to dialects, staff had access to electronic speech aids which allowed direct translation to the patient, so staff could tell them what they were going to do.

There was also a service whereby staff could arrange for a volunteer befriender who spoke the same language as the patient to attend the hospital to speak socially with them. This was responsive practice.

Access and flow

People could access the service when they needed it and received the right care promptly.

There were two admission pathways at the hospital, for the brain injury service and specialist continuing care. As of 25 November 2019, the waiting list for the brain injury service waiting list was 10 patients; the waiting list for the continuing care wards was six patients. Patients from the brain injury service were discharged into the community or progressed to other areas of the hospital for further care. Staff reviewed waiting list times and progress at the daily bed management meeting and weekly referral meetings.

There were admission and discharge policies which outlined the process of patient access and flow through the hospital. All enquiries about admissions and referrals were dealt with on the phone by admission coordinators. Coordinators ensured all assessments were completed and information was gathered to make an informed decision over the patient's suitability for admissions. The provider told us coordinators kept in contact with referrers throughout the process, giving estimated timescales where possible. Staff told us they started planning for patient's discharge from the brain injury service around four weeks in advance.

Learning from complaints and concerns

It was easy for most people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

People and their relatives told us if they were unhappy with any aspect of their care, they would speak with a member of staff. People were given the option and asked if they wanted their concerns or complaints to be investigated informally or formally. One relative said, "If I had concerns - I would speak up and they would listen." Staff we spoke with could give examples of when they had dealt with formal and informal complaints or concerns on their ward, and the learning identified locally.

The hospital had an in-date complaints policy. The hospital provided us with information which stated informal concerns and formal complaints were recorded on the electronic incident reporting system. Concerns could be raised to any member of staff, including the patient experience officer. Informal concerns were managed at ward level and addressed by the ward manager within 48 hours of being raised. Complainants could request written feedback, but this was usually provided verbally. If complainants were not satisfied with the management of their concern, they could raise a formal complaint. Formal complaints were overseen by

the patient safety and quality team, who allocated a suitable person to investigate and respond to any concerns raised. Written responses were sent within 20 working days and complainants could meet with the investigator if they wished. Patients who were unable to communicate but could use eye gaze technology, were able to use this to send messages to staff to raise concerns. The hospital complaints policy stated it may be necessary to seek assistance from the speech and language therapy staff if the patient has communication difficulties in order to ensure they are supported to voice their concern, and on occasions an external interpreter may also be required to assist in communicating. However, we did not see an easy to read complaints policy or form available.

The hospital received 144 complaints between November 2018 and October 2019 and managed 27 of those under the formal complaints procedure. Of these 11 were substantiated, six were partially substantiated, and ten were unsubstantiated.

The hospital provided us with details of actions they planned to take from feedback received in 2018, which was displayed in a 'you said – we will' format. For example, in response to feedback that better communication with patients, residents and their families was needed, the hospital stated they planned to increase attendance to 'Communication with Patients' training by nursing and medical staff, delivered in part by patients. This involved patients who used eye gaze or other assistive communication technology, participating in training staff and trustees on how to use letterboards. The provider told us this training enabled non-specialists to enter into the experience of and communicate with patients.

Are long term conditions services well-led?

Requires improvement

Our rating of well-led went down. We rated it as **requires improvement.**

Leadership

Not all leaders had the necessary skills and abilities to run the service. Some did not always demonstrate that they fully understood and managed the challenges of leading this type of service. However, executive team members were visible and approachable in the service for patients and staff, and they supported staff to take on more senior roles. Local leaders were experienced, skilled and understood the priorities and issues their wards faced.

The hospital had an executive team, who were responsible for its day to day running. The executive team consisted of the chief executive, director of finance, director of governance, director of nursing, director of fundraising and communications, director of service delivery and the medical director. In addition, there was a chair and, at the time of the inspection, 14 trustees who provided non-executive scrutiny and participated in committees. The career backgrounds of the executive team included previous experience in director and senior management roles and postgraduate qualifications.

However, we were not assured that all executive directors understood the challenges to the quality of care, nor could they identify the actions needed to address them. During interviews, some executive directors were not able to articulate how information flowed to and from the hospital wards to the executive team and could not identify how they might recognise emerging risks in the organisation. In addition, some executive directors were not able to comment on discussions that had been held around required improvements to safeguarding processes, since the previous concerns arose in November 2019. Not all leaders could comment on the quality of the root cause analysis training. This meant we could not be assured that all leaders were aware of and fully addressing the risks, issues and challenges in the service, nor could we be assured that leaders were clear around their roles and accountability for quality.

There was a matron responsible for each service line in the continuing care service, brain injury service and specialist services; and they reported to the head of nursing. The head of nursing reported to the director of nursing. Matrons were responsible for the line management of each ward manager.

Leaders told us each director was a 'buddy' to two ward managers and carried out ward visits around twice per month. Following our inspection, senior leaders provided

us with some examples of where discussions between directors and ward managers via the buddy system had resolved issues. For example, on Glyn Ward, the ward manager highlighted problems with the clinical room and the director arranged for new locks and replacement of benching.

Trustees could visit the hospital on an open invitation and participated in mock CQC inspections. Staff told us that executive directors were visible in the organisation and they felt comfortable to approach them. For example, senior nurses told us they had frequent contact with the director of nursing.

Staff were positive about their local leaders. Staff told us they felt their manager had "the skills, motivation and support to make a difference" and local leaders were driven and inspiring. Staff could give examples of where local leaders had listened to them. For example, staff told us the ward manager had taken prompt action to fix an over-active alarm system. We met staff who were acting up into roles, such as acting matron. Staff told us they were given the opportunity to develop, through internal rotation, research, or further study. Following our inspection, the provider told us improvements in ward level leadership had been led by the director of nursing who had carried out further study on the topic. Local leaders had succession plans. There was a monthly leadership forum and leadership development programme. The chairman also spoke positively about the trustees and executive directors and told us it was "the best team I've ever had the privilege to be in charge of."

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The hospital had an overall strategy entitled 'Our plan for the future: 2018-2022, moving towards growth'. This outlined key areas of focus included a clinical action plan, ward refurbishment, continued investment in staff and information technology, maintaining sustainable finances, effective fundraising, and research. Leaders updated staff on the progress of the strategy through the leadership forum. Leaders also reported on the progress of the strategy to the public through the annual quality account.

There were also separate strategy documents for specific areas such as nursing, fundraising, research and a three-year clinical strategy. Each strategy was authored and led by members of the executive team.

Staff knew about the plans and vision for their ward and could explain what it meant for their work. For example, staff told us of plans to expand the ventilator unit, wider participation in the Putney programmes, and improving electronic working particularly in relation to electronic patient records.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The hospital had a set of four values, entitled the Putney Way, which were developed in partnership with staff at roadshows during 2019. The values were 'seeing the whole person, delivery on promises, willingness to learn, and honesty and integrity'. Staff we spoke with could demonstrate they understood the values, and the values were a key part of the Putney Nurse and health care assistant programmes.

Staff told us they felt valued by their managers and the organisation. A patient told us that they felt they had a "very good manager on the ward who has invested in staff. The staff like being here and they get promoted because they learn so much". Staff described their work as "challenging but rewarding". Some staff told us they loved coming to work and enjoyed their roles. Many members of staff told us they could rely on the support of their colleagues. Local leaders told us they were keen to recognise success amongst their staff. For example, in designing the 10 minute 'Putney Gathering' shared learning boards, the head of nursing told us if the 10 minute timer ran out, they would move straight to celebrating success to end the discussion on a positive note. Key messages and learning from incidents were discussed first to ensure they were covered.

The provider told us that staff were encouraged to voice and act upon any concerns they may have. There was a

'Freedom to Speak-Up: Raising a Concern' policy, which outlined the stages of how staff could raise concerns and how they would be responded to. One of the hospital trustees acted as a designated Speak Up Guardian and staff could contact them on an anonymous phone line. The policy outlined that staff could contact the Speak Up Guardian once they had raised their concerns through the line management structure and were not satisfied with the response. Staff consistently told us they would be comfortable to raise concerns and some staff could give us examples of where they had done so.

Staff on Wellesley ward told us the ward manager promoted wellbeing amongst staff and recognised when staff were getting burned out. There were sessions available for staff on 'the importance of self-care and resilience' which staff told us were helpful and supportive.

On our last inspection, we were concerned that healthcare assistants on Chatsworth ward did not have the training to cope with violence and aggression displayed by some patients. On this inspection, we found that training had been arranged, and the provider told us 16 members of staff had attended so far. Leaders had initiated an action plan and checklist of care for staff encountering violence and aggression, which had been rolled out to all ward managers.

Governance

Leaders did not always operate effective governance processes, throughout the service or with partner organisations.

Senior leaders provided us with a copy of their governance and committee structure, which they entitled a board assurance framework. This showed 11 committees including the clinical risk and incidents committee, mortality review and medicines management committees, which fed up to the board through the patient safety and quality committee. These committees provided assurance reports for the executive. There was also an accompanying board committee terms of reference document which set out how the committees provided assurance to the board that the executive was carrying out its functions.

However, during interviews, not all executive directors were able clearly to articulate the governance structures of the organisation. Senior executives described how they were informed of incidents, such as through the executive management team meeting (as detailed below). However, we found an incident where a nurse had held a patient's nose to encourage them to swallow medication, which was potential harm or abuse. This incident had been classified as no injury, and although the nurse apologised to the patient, the principles of the Duty of candour had not been applied. Furthermore, the provider did not notify CQC or the local authority safeguarding team of this incident. Instead, we saw correspondence between a senior leader and senior executive, which outlined internal actions that would be taken such as reviewing the nurse's medicine competencies and issuing a letter of concern.

We also found an example of where we could not be assured governance arrangements were working effectively regarding safeguarding. In November 2019, we took enforcement action in relation to safeguarding and governance of the service. We imposed a condition in relation to safeguarding, which the provider stated they had complied with. However, on follow up and during this inspection, we raised our continuing concerns about safeguarding, and the provider re-opened the action, in order to work towards achieving compliance with the condition.

Furthermore, when we revisited the events of November 2019 with executive leaders, we were concerned about the pace of improvement. Although the executive team had responded to the enforcement action and developed action plans, we were concerned that wider learning and assurance outside of the area identified had not been comprehensively implemented. We were not assured that the board had taken sufficient steps to improve oversight of quality and risk, in a timely manner. This meant we could not be assured that the arrangements for governance and performance management were fully clear or operating effectively.

Following our inspection, the provider told us that executive leaders attended a variety of committees, which were also attended by staff and managers. The provider told us this was an opportunity for executive leaders to receive feedback from staff and managers.

On Mondays the patient safety and quality team sent a list of serious incidents and complaints to the executive management team. The director of service delivery told us the director of nursing, director of governance and four

operational managers reviewed the list to check that it was up to date, and rated the risks red, amber or green (RAG) based on the status of the investigation. This list was then put on the agenda for the Tuesday executive management team meeting, which included the chief executive and executive directors. Executive leaders told us the executive team went through the serious incidents at this meeting and the director of nursing answered questions.

There was a 'stand-up' operational meeting on a Monday morning and Friday afternoon. We received a copy of the agenda for the stand-up operational meeting for a Friday. The agenda covered key staff on call, incidents that had occurred the previous week, comments on the weekly shared learning, patient care concerns, expected admissions and discharges, new safeguarding concerns, staffing equipment, facilities or drug issues. Leaders told us they were considering ways in which they could triangulate incidents, complaints and feedback to determine if there were any themes, which was work in progress.

Staff we spoke with on the wards were aware of what they were accountable for and to whom. The head of nursing had oversight of work and line management of the matrons. The director of nursing held executive responsibility for nursing. There were separate reporting arrangements for allied health professionals and medical staff who covered the wards. For example, there were monthly ward meetings and monthly forums for allied health professionals by discipline. Following our inspection, the provider told us executive leaders managed short-life action groups to resolve particular human resources problems. For example, short-life action groups had previously been held to arrange weekly pay for bank staff, restructure the ward administrator role and align healthcare assistant pay to experience and responsibility.

At the time of our inspection, a ward-level approach to shared learning was being rolled out. This initiative had been introduced and led by the head of nursing who joined the hospital in September 2019, and the board had approved their proposal for the initiative. Following our inspection, the provider told us this shared learning process was not part of the committee structure of the hospital, but the clinical risk and incident committee would review the effectiveness of it.

Managing risks, issues and performance

Local leaders and teams used systems to manage performance. They had plans to cope with unexpected events. However, mitigation actions to address safeguarding risks were not always robust.

On our last focused inspection some key staff such as a ward manager and a matron were unable to articulate the top three risks for their respective wards. On this inspection, we found the top three risks were displayed on the learning board on the ward, and staff were able to explain them. The clear display of top three risks on the ward had been initiated by the chief executive. The head of nursing subsequently worked with each ward to determine what the risks were and arrange for them to be displayed. For example, on Chatsworth ward, the top three risks were management of medication, patient behaviour and ensuring there were enough staff to meet patients' complex needs. Staff told us the top risks were decided upon according to how many incidents were logged and themes that emerged. The display also showed detail on what mitigations were in place to address the risk. For example, all nurses were required to redo their medicines management competencies including practical observations. Ward managers told us risks were also shared in handover meetings. This was an improvement since our last inspection.

There was a hospital-wide risk management strategy and policy. This outlined how risks were identified and reviewed by the executive management team and trustees. The provider identified its principal risks as the safety of patients, the quality of care, recruitment and retention of staff and financial sustainability. These were broken down further into specific risks in the organisational risk register. We saw examples of where risks have been mitigated. For example, the risk of clinicians failing to recognise patients were deteriorating was mitigated by training, updating guidance and introducing an electronic observations system. On our inspection we saw this was the case and staff were able to recognise promptly when patients deteriorated.

There was a risk register for the hospital which was divided into organisational, clinical, medicines management, finance and information governance risks. The risk register we saw following the inspection, included risks we had identified, including the risk of potential harm or neglect to patients caused by low

standards of care. The provider had control measures, gaps in controls and mitigation actions. One mitigation action was for the provider to review and update its safeguarding policy. However, we were not assured the safeguarding policy we saw during the inspection, reflected the patient demographic and complexity of all their needs, including communication and decision making. The policy also did not address issues of consent and mental capacity and we were concerned that this did not reflect or comprehensively include best practice.

The audit and risk committee reviewed all significant risks quarterly before consideration by the board of trustees.

Departmental risk registers were updated monthly and incorporated into the corporate risk register which was reviewed monthly by the executive management team. Risk registers were then reviewed by the hospital board committees quarterly; and through board commentary quarterly.

The provider had a major incident policy which outlined the proposed response to all major incidents which may have affected the provision of normal services.

Following our inspection, the provider told us there was a support services risk register, and at the end of every board committee and the board itself, members are asked to identify any emerging risks. The provider told us these were recorded and considered by the executive.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, we found three examples of incidents where the hospital did not notify external organisations as required.

Required data or notifications were inconsistently submitted to external organisations. In the period from February 2019 to February 2020, the hospital submitted 65 statutory notifications to the CQC as required under the Health and Social Act, 2008. However, we found three examples of incidents where the hospital did not notify external organisations as required. This included incidents of potential abuse or harm. Providers must notify CQC without delay, of specified incidents stated in paragraph (2), Regulation 18, Care Quality Commission (Registration) Regulations, 2009. For further detail, please see above under Safeguarding and Incidents.

We viewed the patient safety and quality report for December 2019 which gave an overview of safety performance across the hospital including incidents, staffing, and medication management. This report was issued on a quarterly basis and was discussed in the patient safety and quality committee which fed up to the board. Following our inspection, the provider told us this report formed the basis of the patient safety and quality committee's assurance to the board.

At the time of our inspection the provider was working towards fully embedding an electronic patient records system. We saw this was a secure and user-friendly system.

The hospital information governance committee provided operational support and strategic direction to help to ensure the hospital complied with good information governance practice.

Senior clinicians communicated with commissioners to make predictions on the number of weeks a patient would need to be on the neuro-behavioural pathway care.

The hospital finance team worked with managers to ensure budgets were sufficient, to explain variations, and to inform forecasts and subsequent years' budgets.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There was a quarterly patient representative committee (PRC) which was chaired by an RHN Trustee. There was a ward representative on each ward who was usually a relative of a patient on that ward. The provider told us the PRC was a forum for ward representatives to give senior RHN staff feedback about their own experiences, as well as the experiences of other people on the wards. During the PRC, staff gave updates to ward representatives regarding changes to services, such as refurbishments or

service improvements. Ward representatives also received feedback about actions carried forward from previous meetings. The provider told us that in addition to PRC, ward representatives met with the patient experience and safety officer on an ad hoc basis to provide additional feedback and discuss developments within the hospital. We saw names and photographs of the ward representative were displayed on each ward we visited.

We saw the ward managers held weekly open sessions for patients and their families to drop in and ask questions or provide feedback.

The hospital undertook mock inspections twice per year, involving staff, patients and relatives in the process. There was an annual 'experience of care week' event, which was an international initiative the hospital participated in. In 2019, the patient experience and safety officer facilitated patients, relatives and staff discussing the topic of 'what would brighten your day?'

There was a hospital wide staff survey. An action plan from this survey was used to try to ensure feedback from staff was used to improve services. The most recent results from the 2019 survey showed that 91% of staff who participated felt proud to work at the hospital, 98% were aware of the hospital values, and 98% knew how to raise a concern. Following our inspection, the hospital also provided us with some additional staff survey results. This showed 85% staff had confidence in the leadership skills of their manager, and 89% of staff believed communication between senior management and staff was effective. This was an improvement from 81% and 83% respectively in 2018. Staff told us they received a weekly email bulletin from the chief executive with news and updates.

Following our inspection, the provider told us executive leaders used clinical staff feedback to influence new business development initiatives, such as the provision of a monthly orthoptist clinic.

There was an annual survey for patients and families which was running at the time of our inspection. The provider told us working parties were in place to address issues and suggestions for improvement in response to the survey.

On each ward, staff had developed their own methods of engaging with patients and relatives. For example, on Devonshire ward, the notice board had photos of the ward staff holding up whiteboards where they had written what they loved about being a nurse.

The provider had been participating in clinical quality review group (CQRG) meetings which included NHS England/Improvement and clinical commissioning group (CCG) commissioners, since it was initiated in 2017. These meetings initially occurred every other month but moved to quarterly in 2018. The purpose of the CQRG is to monitor the quality of services. Since December 2019, the CQRG had been held on a monthly basis and included representatives from CQC. This was agreed by the CQRG membership and included in the Terms of Reference.

At the December 2019 CQRG, the local CCG, stated that they had written a paper highlighting the responsibilities of the commissioners and the organisation. Due to the specialist nature of the hospital, there were approximately 50 CCGs that commissioned care at the hospital. Historically, the local CCG had established the role of 'oversight', because of the location to the hospital and for CCG commissioned patients. NHS England/ Improvement had 'oversight' of specialised commissioned patients. An agreed action was for the local CCG to send the paper to NHS England/ Improvement, to agree a joint commissioning process of communication, in partnership with the provider.

During the inspection, senior leaders were asked how the organisation captured concerns raised, and subsequent learning from external monitoring. Some leaders were not able to articulate how learning was shared across all CCGs. We were told by some leaders that concerns were responded to on an individual basis. We were concerned that this was not an embedded system, and there was the risk that lessons or themes could be missed. Following our inspection, the provider gave us a copy of their agreed process for serious incident management. The provider told us this was reported to the executive team weekly, and there was frequent communication between the hospital and clinical commissioning groups.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Requires improvement

Long term conditions

The hospital had a research strategy for 2019-2024 which was driven by the hospital's guiding principles of 'Excellence, Impact and Reputation.' During our engagement with the provider leaders demonstrated a commitment to supporting research and innovation amongst staff and embracing new developments and technology. At the time of writing, three staff at the hospital were undertaking further study on topics related to neuro-disability. There were many examples of ongoing projects on different themes relevant to the care provided by the hospital. The research strategy was focused primarily on how research could benefit patients in specific areas, such as breathing and respiration, and assistive technology.

Leaders also encouraged staff to bring forward ideas to improve their ward areas, and teams could present to the board in order to bid for funding.

Following the inspection, the provider told us that the executive team led the development of the research strategy**.** The process to produce a draft strategy (which took input from a number of staff members engaged in research) was for the associate director of research to hold a series of meetings with the three clinical directors, including the director of nursing, managing director, and the director of service delivery, together with the chief executive.

Outstanding practice and areas for improvement

Outstanding practice

- We saw many examples of responsive practice from staff to meet patient's individual needs and provide holistic care. Staff created innovative ways to meet patient's sensory and social needs, and supported patients to register to vote.

Areas for improvement

Action the provider SHOULD take to improve

- Continue work to ensure all repositioning charts are fully completed on Chatsworth ward.
- Continue work to ensure all staff are up to date with their mandatory training.
- Consider how good handover practice on other wards could be incorporated into handovers on Chatsworth ward.