Cygnet Hospital Bierley

Quality Report

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

Ratings

Overall rating for this location	**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**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

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

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

Summary of findings

Overall summary

We did not plan to re-rate the hospital at this inspection as it was a focused inspection of key lines of enquiry related to the safe, caring and well led key questions only. However due to the inspection findings we have re-rated the core service as requires improvement.

We rated Cygnet Bierley as requires improvement because:

- Staff did not consistently review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance or the provider's policy following the use of rapid tranquilisation.
- Staff utilised mechanical restraint to transport a patient to seclusion which was against hospital policy and restrictive interventions training.
- It was not clear from documentation that staff made the decision to end seclusion at the earliest opportunity on all wards.
- Staff, especially those on the psychiatric intensive care unit ward, cited negative morale and lack of team cohesion as a result of the whistle-blowing complaints being made to the Care Quality Commission.
- Some patients and carers told us that staff did not always engage with them in a positive manner.
- Governance systems in place were not entirely effective in identify areas of concern found during inspection.

However, we found the following areas of good practice:

- The ward environments were safe and clean. Staff minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Patients told us they felt safe, listened to, and respected by staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	
Forensic inpatient or secure wards	Requires improvement 	
Personality disorder services	Requires improvement 	

Summary of findings

Contents

Requires improvement

Cygnet Hospital Bierley

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Personality disorder services

Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is an independent mental health hospital provided by Cygnet Health Care Ltd. The hospital provides care for up to 63 male and female patients across four different wards:

• Bronte ward is a 16-bed forensic low secure service for women

• Shelley ward is a 16-bed forensic low secure service for men

• Denholme ward is a 15-bed psychiatric intensive care unit for women

• Bowling ward is a 16-bed specialist personality disorder service for women

The hospital has been registered with the Care Quality Commission since April 2009 to carry out the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury.

The Care Quality Commission last carried out a comprehensive inspection of this hospital in November 2019. At that inspection we rated the service as 'good' overall, with the hospital in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Regulation 12 Safe care and treatment

Our inspection team

The team that inspected the service comprised of four CQC inspectors and one mental health nurse specialist advisor. The team members attended the service on different days. Visits were unannounced and took place on 6 August 2020 during the day shift and 11 August 2020 during the evening/night shift at the hospital. An expert by experience was unable to attend the inspection due to current COVID-19 restrictions.

Why we carried out this inspection

We inspected this service following receipt of specific and significant concerns about the safety and culture within the service.

How we carried out this inspection

This was an unannounced inspection where we focused on specific key lines of enquiry in the safe, caring and well led domains. We inspected the service over two days including visiting the service out of hours, in the evening.

Before the inspection visit, we reviewed information that we held about the service, conducted Mental Health Act monitoring visits, spoke with stakeholders including patients, carers, commissioners, advocacy, and the local authority safeguarding team, and met with senior managers within the service for regular engagement meetings.

During the inspection visit, the inspection team:

• visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients

• spoke with 15 patients who were using the service

Summary of this inspection

- conducted observations of patient and staff interactions
- spoke with the acting service manager, acting clinical lead and operations director
- spoke with 18 other staff members; including nurses, healthcare assistants, occupational therapists, and social workers
- attended and observed two hand-over meetings
- reviewed medication management on all four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Prior to inspection, on 19 and 22 June 2020, we spoke remotely with nine patients across the four wards following concerns received via notifications to the Care Quality Commission. During inspection we also spoke with a further 15 patients across the four wards.

Patients on all wards were generally positive in their feedback. They told us that they felt safe, staff listened to them, staff were fair in their decisions, and were respectful, polite, and treated them with privacy and dignity. However, patients told us that they were often bored and felt there were limited activities available on the wards, two patients told us that some staff had said inappropriate things to them or had spoken to them in an unfavourable tone. These behaviours are not in-line with the provider's own vision and values of caring and respect.

Patients told us they had no problems contacting family members during the COVID-19 pandemic whilst visitors were unable to attend the hospital. Prior to inspection, on 19 and 22 June 2020, we spoke remotely with six carers or family members of patients across the four wards. All carers we spoke with told us their general impression of staff was positive. However, two carers told us that some staff could be aloof and didn't always have time for them, and one carer told us that the patient on the ward felt that staff often responded to requests for things on the ward in a negative manner. Whilst carers were largely positive in their feedback, they did tell us they did not feel as if staff actively invited and encouraged them to attend meetings involving the patient and they felt frustrated that staff had not considered a formal way of keeping them informed during the COVID-19 pandemic.

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

We found a breach of regulation during this inspection. The rating remains the same, due to the breach of regulation the rating was limited to Requires Improvement.

We found the following areas the hospital needs to improve:

- Staff did not consistently review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance or the provider's policy following the use of rapid tranquilisation.
- Staff utilised mechanical restraint to transport a patient to seclusion which was against hospital policy and restrictive interventions training.
- It was not clear from documentation that staff made the decision to end seclusion at the earliest opportunity on all wards.

However, we found the following areas of good practice:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- All staff had received and were up to date with training in reducing restrictive practices.
- Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Are services effective?

Good

We did not rate the effective key question at this focused inspection as we did not inspect this domain. The rating of Good is from our previous inspection on 26-27 November 2019.

Are services caring?

Good

We did not re-rate the caring key question at this focused inspection as we did not inspect all key lines of enquiry. The rating of Good is from our previous inspection on 26-27 November 2019.

We found the following areas of good practice:

- Patients on all wards told us that they felt safe. They told us staff listened to them, were fair in their decisions, were respectful, polite, and treated them with privacy and dignity.

Summary of this inspection

- Patients knew how to access support from an advocate.
- Patients and carers told us they knew how to complain and raise concerns and would feel comfortable to do so.

However, found the following areas the hospital needs to improve:

- Patients told us that they were often bored as there were limited activities available on the wards.
- Carers did not feel as if staff actively invited and encouraged them to attend meetings involving the patient.
- Some patients and carers raised concerns regarding staff attitudes towards them.

Are services responsive?

We did not rate the responsive key question at this focused inspection as we did not inspect this domain. The rating of Good is from our previous inspection on 26-27 November 2019.

Good

Are services well-led?

We found a breach of regulation during this inspection related to concerns about the governance and leadership of this service. This limits our rating of this key question to requires improvement.

We rated well-led as requires improvement because:

- Our findings from the other key questions demonstrated that governance processes did not operate effectively in order to manage performance and risk, particularly in relation to seclusion and physical health monitoring of patients.
- Staff, particularly those on the psychiatric intensive care unit ward, raised concerns about low morale and difficult staff relationships. Plans to address these areas of concern were still being developed.

Requires improvement

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We did not review Mental Health Act responsibilities as part of this inspection, but we did conduct a remote Mental Health Act monitoring visit on the male low-secure forensic ward prior to inspection on 18 June 2020. We did not identify any concerns following this visit in relation to the key lines of enquiry subsequently inspected.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review Mental Capacity Act and Deprivation of Liberty Safeguards as part of this inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Personality disorder services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Layout of the wards allowed staff to observe most parts of the wards. The use of CCTV and staff presence in communal areas also aided staffs' ability to maintain observation of any areas where clear observation was not possible. Additional staff had been rostered to support with cleaning tasks whilst a member of domestic staff was unable to work and during the COVID-19 pandemic to support with additional cleaning of the wards.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Prior to inspection we received a whistle blowing notification stating that ligature knives were not sharp enough and that staff did not know where emergency bags were kept. There were 20 ligature knives located across the four wards of the hospital. Managers told us that knives were single use and were sent externally for sharpening following use. A ligature sharpening log was in use to document when knives were sent for sharpening and we were shown invoices that demonstrated regular sharpening of ligature knives. All staff we spoke with on inspection knew where emergency bags were located.

Managers told us that there had been a recent incident whereby a member of agency staff could not find the emergency bag when asked to do so. As a result, a reminder was sent to all staff to identify emergency bag locations and the agency staff induction checklist was amended to be more robust.

Mandatory training

All permanent and bank staff had received and were up to date with training in reducing restrictive practices, and eighty percent were up to date with personal safety training. The provider required all agency staff to be up to date with required training before working at the hospital.

Assessing and managing risk to patients and staff

Management of patient risk

Staff followed policies and procedures for use of patient observation. Staff were allocated to patient observations at the start of each shift and allocations were written on a notice board in the ward offices. Staff also discussed and documented observation levels at shift handover meetings. We checked observations records, and these were completed correctly on all wards. However, on the psychiatric intensive care unit ward it was observed that some staff were allocated to undertake continuous periods of observations above the general level for longer than two hours, which is against National Institute for Health and Care Excellence guidance. Senior staff on the ward stated that staff would be relieved for quick breaks, but this was not scheduled and there was no process to ensure that this took place.

Use of restrictive interventions

Patients we spoke to on all wards told us that staff made attempts to avoid using restraint by using de-escalation

techniques first and would restrain patients only when these techniques failed and when necessary to keep the patient or others safe. Patients told us that restraint happened very rarely, they felt restraint was used as a last resort, and that staff were good at de-escalating situations verbally. We reviewed eight incident records across all wards where restrictive interventions had been used and found that staff had clearly documented attempts to de-escalate patients prior to the use of restrictive interventions, including rapid tranquilisation.

However, staff did not consistently review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance or the provider's policy. We reviewed 30 post restrictive intervention observation charts between April and July 2020 across all four wards which contained records of physical health monitoring following the use of rapid tranquilisation. We found that on one occasion on the male low-secure forensic ward and one occasion on the personality disorder ward observations were not conducted for a minimum of one hour. We also found that on eight occasions on the personality disorder ward and five occasions on the low-secure forensic wards staff had only recorded level of consciousness, and guidance and provider policy states that as a minimum staff need to also observe respiration. This was a concern at our previous inspection in November 2019, following which we told the provider they should ensure that monitoring and observations following the use of rapid tranquilisation are fully completed in line with the provider's policy and guidance from the National Institute for Health and Care Excellence. Additionally, on the psychiatric intensive care unit ward we reviewed physical health monitoring post-administration of Clopixol-Acuphase (a medication given to initially treat acute psychoses with a duration of effect of 2-3 days). The provider's policy states that due to the length of action and potential side effects, follow up should last longer than post rapid tranquilisation guidance of one hour, and clinical observations should be carried out on a regular basis for 72 hours. However, we found that on four occasions between July and August 2020 physical observations lasted only 42, 30, 56 and 7 hours respectively with no clear rationale for why they were stopped before 72 hours.

Shortly prior to inspection we were notified of one instance of mechanical restraint on the psychiatric intensive care unit ward whereby staff used a fire blanket to transport a patient to seclusion. Within the providers own internal investigation staff stated that this method had been used before by numerous members of staff. Staff involved initially denied strapping the patient into the blanket until shown CCTV, after which they conceded they had done so. This method of transporting a patient was against provider policy and was not taught within any restrictive interventions training. Of particular concern was that staff reported that whilst they knew they should not have used the fire blanket in this way, they did so as they had witnessed it being used previously and did not feel able to challenge the decision of other staff members involved. However, staff reported this as an incident, and senior managers investigated, with learning identified around staff training , management oversight and audit of seclusion incidents.

Prior to the inspection we received anonymous whistle-blowing and patient concern notifications suggesting that seclusion was being used as a threat to patients. During inspection we reviewed 10 episodes of seclusion which took place across the four wards between 1 April 2020 and 29 July 2020. We found that when a patient was placed in seclusion, the rationale given for this was clear and there was no evidence of seclusion being used as a threat or being used inappropriately. Patients we spoke with told us that staff were fair in their decisions and some patients who had experience seclusion reflected on this and told us they felt it was proportionate to the risk they presented. Senior managers conducted monthly audits which included a review of evidence of justification for the use of seclusion and actions were taken if any concerns were identified. However, it was not clear that staff made the decision to end seclusion at the earliest opportunity on all wards. On the psychiatric intensive care unit ward, we reviewed five records and found that within all five there was reference to the ending of a seclusion a number of hours before it actually ended. For example, one nursing review suggested that the patient's behaviour was such that seclusion was ready to end, but to await a multidisciplinary review decision, which did not take place for a further 3 hours. On another occasion reviews referred to the patient being settled but kept in seclusion due to the need to create a long-term management plan for the patient. Seclusion did not end for another 68 hours after the first mention of the patient being settled. There were also numerous references to patients not showing remorse or insight into their actions, as well as references to not

being able to assess mental state for long periods because patients were asleep. On the low-secure forensic wards we reviewed three records and found that seclusion did not end at the earliest opportunity on one occasion. However, we were satisfied that seclusion ended at the earliest opportunity within our review of two seclusion incidents on the personality disorder ward. Monthly seclusion audits did not review this aspect of seclusion.

Safeguarding

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would feel confident to raise safeguarding concerns and were encouraged to do so by managers. Staff received mandatory training in adult safeguarding up to level three and at the time of inspection 85% of required staff were compliant with this training.

The hospital had a safeguarding lead as well as a number of social workers who were able to support staff with any safeguarding concerns. Staff could access safeguarding handbooks on each ward and posters were present informing staff what to do if they had any safeguarding concerns. The provider also had a corporate safeguarding lead who provided support and supervision to the hospital's safeguarding lead and could be contacted by any staff members for support and advice. Safeguarding was a standard agenda item at monthly staff team meetings and records showed staff discussing open and new safeguarding concerns on the wards.

The safeguarding lead attended daily meetings on the wards as well as reviewing all incidents reported by staff to establish any safeguarding concerns. They then attended a daily management meeting where concerns were discussed with senior managers and ward managers within the hospital and any required referrals would be made to the local authority that hadn't already been done . The safeguarding lead therefore oversaw all safeguarding concerns, allowing them to identify any themes or trends and act on these appropriately, for example putting individual patient management plans in place. The safeguarding lead had a positive relationship with the local authority safeguarding team whom they could approach for support and advice.

As a result of whistle blowing notifications and reported patient concerns to the Care Quality Commission the safeguarding lead had also recently implemented safeguarding clinics on each of the wards for patients to attend and raise any concerns on a weekly basis.

Medicines management

Medication was stored appropriately on all wards in line with the provider's policy. We reviewed 33 patient medication cards and found that medication prescriptions were signed and dated appropriately when given to patients.

Reporting incidents and learning from when things go wrong

Prior to inspection we received a large number of whistle-blowing notifications. The concerns referred to had not been directly reported as incidents to the provider. The vast majority of callers remained anonymous, meaning we were unable to fully follow up the concerns reported. We also received information to suggest that incident reports were being amended by senior managers so that they did not accurately reflect incidents as reported by staff.

All staff we spoke to on inspection knew what incidents to report and how to report them. Staff told us they would feel confident to raise incidents and concerns and could give examples of where they had done so, and where managers had investigated and acted where necessary. Managers reviewed all reported incidents on a daily basis and acted to investigate them. Patients and their families were involved in these investigations where appropriate. Staff received feedback from investigation of incidents. Managers took the decision to share whistle-blowing notifications and outcomes with staff to maintain an open and transparent culture. Staff told us they were aware of the whistle-blowing notifications. Senior managers were in the process of developing an action plan in response to concerns.

During inspection we compared details written by staff in patient daily notes to resulting incident reports. We could see no evidence to suggest that incident reports were being amended by senior managers and found incident reports to be an accurate reflection of what was documented within the daily notes.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

We did not inspect this key question as part of this inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Prior to inspection, on 19 and 22 June 2020, we spoke remotely with nine patients across the four wards following concerns received via notifications to the Care Quality Commission. During inspection we also spoke with a further 15 patients across the four wards.

Patients on all wards told us that they felt safe. They told us staff listened to them, were fair in their decisions, were respectful, polite, and treated them with privacy and dignity. Patients we spoke to on all wards told us that restraint happened very rarely, they felt restraint was used as a last resort, and that staff were good at de-escalating situations verbally. However, one patient from the personality disorder ward and one patient from the psychiatric intensive care unit ward told us that some staff had said inappropriate things to them regarding their recovery or had spoken to them in an unfavourable tone.

We observed staff to engage well with patients on all wards. Staff were observed to maintain a patient's privacy and dignity during an incident, interact with patients with patience, and to use distraction and de-escalation techniques to good effect.

Patients told us that they were often bored as there were limited activities available on the wards. Daily patient meetings took place on each ward whereby patients could make requests for specific activities and were told about events taking place that day but still felt there was little for them to do. There were activity co-ordinators assigned to each ward, but a health care assistant was providing support on the psychiatric intensive care unit ward due to staff sickness. Senior managers acknowledged activities on this ward had been limited of late due to the acuity level of patients. Patient feedback regarding lack of activities was provided to senior managers and as a result funding was sourced for three further activity co-ordinators to be recruited to support across the four wards.

Involvement in care

Patients we spoke with told us they knew how to access support from an advocate. Prior to COVID-19 the advocate spent time on all the wards on a weekly basis. During COVID-19 the advocate was contactable via phone; details of which were available to patients. We spoke with the independent mental health advocate who told us they did not have any overarching concerns with regards to the hospital or safety of the patients.

Patients told us they knew how to complain and would feel comfortable to do so. Patients on all wards gave examples of when they had made complaints and told us these were investigated by staff and responses were provided, and where appropriate changes made as a result.

We reviewed minutes from patient community meetings on each ward from April to July. It was unclear how regularly meetings were meant to take place as some wards only had two in a four-month period and other wards had more than one a month. On the personality disorder and low-secure forensic wards meetings followed a clear agenda and we could see that patient feedback about the wards was listened to and feedback provided. For example, patients gave feedback about the food and this was passed to the catering team to action. However, on the psychiatric intensive care unit ward meetings did not follow an agenda and there was no evidence of any feedback given to patients following suggestions made.

Patients told us they had no problems contacting family members and had access to regular telephone calls during the COVID-19 pandemic whilst visitors were unable to attend the hospital. The hospital acquired tablet computers so that patients could utilise video calling facilities.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Prior to inspection, on 19 and 22 June 2020, we spoke remotely with six carers or family members of patients across the four wards. All carers we spoke with told us their general impression of staff was positive. They felt staff were helpful, open and respectful. Carers told us they knew how to complain, would feel comfortable doing so, and that when they raised concerns staff dealt with them quickly and efficiently. Carers had regular contact with patients and staff facilitated visits where possible. However, two carers told us that some staff could be aloof and didn't always have time for them, and one carer told us that the patient on the ward felt they couldn't always ask staff for things due to negative body language. Whilst carers were largely positive in their feedback, they did tell us they did not feel as if staff actively invited and encouraged them to attend meetings involving the patient and they felt frustrated that staff had not considered a formal way of keeping them informed during the COVID-19 pandemic.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

We did not inspect this key question as part of this inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Leadership

At the time of inspection, there had been a number of very recent changes to the management structure at the hospital. The substantive clinical manager had recently left the organisation and the substantive hospital manager was on long-term leave. As a result, the newly recruited quality and compliance lead was acting as clinical manager and a hospital manager from another Cygnet Healthcare Ltd. hospital was acting as hospital manager. These senior staff members had only been in post for approximately two weeks prior to inspection. However, the hospital manager was an experienced manager who understood provider policies and procedures, and the clinical manager had worked at the hospital for around ten years and had a good knowledge of the site. Both had a good knowledge of the whistle blowing concerns received and were actively working on ways to address these and make improvements. Additionally, three of the four wards had newly appointed ward managers. The operations director for the region was working closely with leaders to provide support to them and other staff at the hospital.

Culture

Prior to inspection we received a number of anonymous whistle-blowing concerns relating to negative culture at the hospital. We had shared these with senior managers at the hospital who had begun to implement structures including focus groups and opportunities for staff to meet with senior managers to discuss their concerns.

During inspection all the staff we spoke with, apart from one member of staff, told us they felt respected and valued at work by their colleagues and senior managers. They told us senior managers were approachable and supportive of their needs. All staff told us they felt able to raise concerns internally with regards to patient care without fear of retribution. However, one member of staff told us that they would not feel confident reporting a personal issue with another member of staff if that staff member had a good relationship with managers as they would not feel believed.

Within a number of whistle-blowing concerns received there was reference to a culture of bullying, harassment and racism between staff within the hospital. During inspection we asked staff if they had experienced, or been aware of, any bullying, harassment or racism in the workplace. None of the staff we spoke to had experienced this, but some staff gave examples of where staff members had 'clashed' with one another or fallen out. Staff told us that managers dealt with these situations quickly and effectively. One staff member told us they felt it was harder for black, Asian and minority ethnic (BAME) staff to progress within the organisation and senior managers did acknowledge the lack of representation at a senior level within the organisation. The organisation had recently introduced a BAME network which was open to all staff with the aim of ensuring representation of diverse communities as a substantive part of the organisation at all levels. We

saw that the network was discussed in some staff team meetings but not on all wards. Managers were unclear whether any staff had accessed this network but planned to promote it more widely within the hospital. Following inspection, a member of staff volunteered to become a BAME representative for staff at the hospital.

During inspection we spoke with staff and patients about the general culture at the hospital. None of the staff we spoke to had witnessed, or were aware of, any inappropriate behaviour from staff towards patients and confirmed that if they did see any they would report this to a manager. All the patients we spoke with told us staff were appropriate in their interactions with them, but one patient from the psychiatric intensive care unit ward raised a concern regarding the tone in which a staff member had spoken to them.

Staff on the psychiatric intensive care unit ward did raise some concerns relating to staff interactions with other staff which they felt were largely as a result of the number of whistle-blowing concerns raised. Staff on this ward told us they had been the focus of malicious reports and did not trust some other staff on the ward who they felt did not work well as part of the overall team. Senior managers were in the process of devising an action plan in response to the whistle-blowing notifications which was to address culture on this ward specifically utilising techniques such as reflective practice, skills coaching and training. However, this work was yet to be finalised and so we were not able to see any potential positive impact.

Prior to the inspection in June 2020 senior managers had conducted a closed culture survey at the hospital. Whilst this did not raise any specific concerns with regards to culture, senior managers implemented an action plan to address and improve overall staff satisfaction and engagement. As part of this action plan a freedom to speak up guardian attended the service, staff focus groups were held, daily senior management ward visits were introduced, and an anonymous staff feedback system was implemented. Senior managers had listened to staff feedback and introduced wellbeing aids such as physiotherapy and physical health sessions and advice for staff, and redecoration of staff only areas to give staff space to relax during breaks. This work was ongoing at the time of inspection.

Governance

Prior to inspection we were concerned about a decline in governance systems at the hospital. Following a comprehensive inspection in April 2018 we issued the provider with a requirement notice, stating that they 'must ensure that the governance systems and processes in place are effective and ensure proper assessment, monitoring and mitigation of risks' due to concerns found, including around audit and oversight of monitoring of patients following the use of rapid tranquilisation. During inspection in November 2019 we noted that the provider had acted to make improvements in this area. However, during the current inspection we were once again concerned about the lack of oversight in relation to monitoring of patients following the use of rapid tranquilisation as there were concerns policy and guidance was not followed in over a third of records reviewed. From April 2020 the provider had reduced their monthly audits in response to the COVID-19 pandemic. As a result, they were reviewing two patients on each ward each month that had received rapid tranquilisation. We reviewed audits from April to June 2020 on each ward and found that where errors were identified with regards to physical health monitoring actions were assigned to ward managers to rectify. It does not appear this audit was effective or that senior managers had oversight of the number of errors occurring as identified during inspection.

We also reviewed audits from May to July 2020 on each ward in relation to the use of seclusion. Senior managers told us they audited the use of all episodes of seclusion, but audits did not identify or address concerns relating to the ending of seclusion in a timely manner, or the use of improper physical restraint techniques to transport patients to seclusion. Additionally, audits had not been fully completed in July 2020 with no clear rationale for why they were not.

Further to the above, there were concerns regarding staff morale and staff feeling unable to report concerns and incidents to senior managers which resulted in a high number of whistle-blowing notifications. These concerns had been ongoing for a number of months prior to inspection but clear action plans were still in development with senior management unclear on how best to address concerns, demonstrating a lack of timely response overall.

Requires improvement

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Requires improvement

We inspected this hospital at location level and therefore findings for this key question are detailed in the acute section above.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

We did not inspect this key question as part of this inspection.

Are forensic inpatient or secure wards caring?

Good

We inspected this hospital at location level and therefore findings for this key question are detailed in the acute section above.

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Good

We did not inspect this key question as part of this inspection.

Are forensic inpatient or secure wards well-led?

Requires improvement

We inspected this hospital at location level and therefore findings for this key question are detailed in the acute section above.

Requires improvement

Personality disorder services

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

Are personality disorder services safe?

Requires improvement

We inspected this hospital at location level and therefore findings for this key question are detailed in the acute section above.

Are personality disorder services effective?

(for example, treatment is effective)

Good

We did not inspect this key question as part of this inspection.

Are personality disorder services caring?

Good

We inspected this hospital at location level and therefore findings for this key question are detailed in the acute section above.

Are personality disorder services responsive to people's needs?

(for example, to feedback?)

Good

We did not inspect this key question as part of this inspection.

Are personality disorder services well-led?

Requires improvement

We inspected this hospital at location level and therefore findings for this key question are detailed in the acute section above.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that monitoring and observations following the use of rapid tranquilisation are fully completed in line with the provider's policy and guidance from the National Institute for Health and Care Excellence.

The provider must ensure that seclusion is used for no longer than is necessary to prevent harm to the patient or to others.

The provider must ensure that staff follow policies and procedures for the correct use of restraint and moving and handling of patients.

The provider must ensure that the governance systems and processes in place are effective and ensure proper assessment, monitoring and mitigation of risks.

Action the provider SHOULD take to improve

The provider should ensure that actions are undertaken to improve staff morale, particularly on the psychiatric intensive care unit ward.

The provider should ensure that carers are actively involved in patient care where appropriate.

The provider should ensure that staff behaviours are consistent with the provider's vision and values when interacting with patients and carers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: **Staff did not consistently review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance or the provider's policy.** This was a breach of regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: **Staff did not consistently ensure that seclusion was ended at the earliest opportunity for patients and staff used unapproved mechanical restraint to move a patient to seclusion.** This was a breach of regulation 13(1)(4)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: **Governance systems and processes in place were not effective in ensuring proper assessment, monitoring and mitigation of risks.**

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17(1)(2)(a)(b)