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Notice of Meeting

Health Scrutiny Committee

Tuesday 14th June 2022 at 1.30 pm

in Council Chamber, Council Offices, Market Street, Newbury

This meeting can be streamed live here:
https://westberks.gov.uk/hsclive

Date of despatch of Agenda: Monday 6 June 2022

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Vicky Phoenix on 07500 679060
e-mail: vicky.phoenix1@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Councillors Claire Rowles (Chairman), Alan Macro (Vice-Chairman), Jeff Beck, Tony Linden, Andy Moore, Jeff Brooks and Gareth Hurley

Substitutes: Councillors Erik Pattenden and Andrew Williamson

Agenda

Part I

Purpose: To present the final protocol for approval.

10 **Appointment of Task Group** 139 - 140

Purpose: To agree the Terms of Reference and Membership for any Task and Finish Group that the Health Scrutiny Committee might wish to appoint in-depth scrutiny reviews:

1) Provisions of healthcare serving new developments.

11 **Task and Finish Group Update** 141 - 142

Purpose: To receive updates from the Chairmen of Task and Finish Groups appointed by the Health Scrutiny Committee:

1) Continuing Health Care Task Group

12 **Health Scrutiny Committee Work Programme** 143 - 144

Purpose: To receive new items and agree and prioritise the work programme of the Commission.

Sarah Clarke
Service Director (Strategy and Governance)

If you require this information in a different format or translation, please contact Stephen Chard on telephone (01635) 519462.

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Health Scrutiny Committee – 14 June 2022

Item 1 – Apologies

Verbal Item

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HEALTH SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON TUESDAY, 5 APRIL 2022

Councillors Present: Claire Rowles (Chairman), Alan Macro (Vice-Chairman), Tony Linden and Andy Moore

Also Present: Marion Angas (Locality Manager), Councillor Jeff Beck, Vicky Phoenix (Principal Policy Officer - Scrutiny), Gordon Oliver (Principal Policy Officer), Belinda Seston (Berkshire West Clinical Commissioning Group), Amanda Lyons (Berkshire West CCG), Duncan Ford (Oxford Health), Lajla Johansson (NHS Berkshire West CCG), Louise Noble (CAMHS), Fay Corder (Hampshire Hospitals NHS Foundation Trust), Sarah Mussett (Hampshire Hospitals NHS Foundation Trust), Elliot Nichols (Hampshire Hospitals NHS Foundation Trust) and Alex Whitfield (Hampshire Hopsitals NHS Foundation Trust)

Apologies for inability to attend the meeting: Andrew Sharp, Paul Coe and Andy Sharp

Councillor(s) Absent:

PART I

23 Minutes

It was noted that Councillor Bridgman was in attendance at the meeting. Subject to this amendment, the Minutes of the meeting held on 10 November 2021 were approved as a true and correct record and signed by the Chairman.

24 Declarations of Interest

There were no declarations of interest.

25 Petitions

There were no petitions received.

26 Children and Young People's Mental Health Services

The Committee considered a report on Children and Young People's Mental Health Services (Agenda Item 5).

Louise Noble (Head of CAMHS and BEDS, Berkshire Healthcare NHS Foundation Trust) gave an update on the CAMHS Tier 4 Service which had moved from an inpatient facility based at Wokingham hospital to a community based model in 2021.

She stressed that the objective of the provider collaborative was to reduce the number of times children are sent out of area for treatment. It was noted that the new service was called the Phoenix Unit. The presentation covered what it offered, the staff team and the delivery timetable. The presentation covered: how the community model improved outcomes for young people; how it supported and involved families and carers; and what was involved in the Eating Disorder programme.

Examples were given of young people and their families who attended the unit and how they worked with staff to develop and practice skills which they could then put in place at

home. Research had shown that this was more effective in providing better longer term outcomes whilst maintaining relationships and community links.

It was noted that this was a developing model. There had been a significant surge in demand for Eating Disorder treatment and so they had reviewed their staffing mix to include a therapeutic cook and had made a slight change to the layout at the unit. There had been significant interest in the new model and details were being shared nationally.

Councillor Andy Moore asked about the male / female balance of Eating Disorder treatment and what strategies that prompted. Louise Noble responded that there were more males presenting than previously, but the balance remained towards more females than males. She explained that one of the reasons for the community based model was that they needed to be very careful about the mix on site, especially at night. The new model had been helpful as it had resulted in less group-focussed self-harm behaviours.

Councillor Alan Macro asked how patients got to the Phoenix Unit. He suggested that it could be a challenge for some people travelling from West Berkshire. Louise Noble agreed that it could be a challenge and they also had patients who travelled from Oxfordshire and Buckinghamshire. In each case, staff would have a discussion with the young person and their family to look at options to help. They also had a social worker on the team who could work with local authority social services teams regarding entitlements. They also had some interventions which were delivered at home. There had been challenges but in each case solutions had been found. Councillor Macro asked if they had any transport. Louise Noble confirmed they did not, but they could help with accessing funding.

Councillor Moore noted the demands on parents and carers of this new model and how the new service supported them. He also asked if parents had any choice in the treatment. Louise Noble advised there were many considerations about the treatment given:

- Did the young person need care at Tier 4 level?
- Were they presenting with symptoms where evidence suggested they would do better in a community setting or in inpatient care?
- What were the particular circumstances of the family and how easy would it be to support the young person?

It was noted that the clinical guidance was to work with the family to help and equip them with skills and to think holistically. Support was also provided to families in the debrief sessions and they had access to support 24/7.

The Chairman asked about the reasoning behind moving to a community model from the inpatient service. Louise Noble responded that other models and research showed that young people were doing better with the community model. NHS England did a review of inpatient need and the success of community models. It was also noted that Willow House had its limitations. There was no need for more beds and the site was not suitable. The community model made sense to meet the local population needs.

Councillor Macro made a request for acronyms to be explained in future presentations.

Councillor Moore asked about the schooling provisions. For example sports or science lab facilities, and how that worked at the Phoenix Unit. Louise Noble explained that they had classroom facilities and outdoor space. The school was Ofsted inspected. There were limitations but the objective was to maintain academic progress.

The Chairman then invited Lajla Johansson (Assistant Director of Joint Commissioning, Berkshire West CCG) to update on the progress on the Local Transformation Plan for Children and Young People's Mental Health which was adopted in September 2021. She

gave an overview of the current local provision and advised the committee of the ambitions of the Plan and the 9 key transformation priorities. She then gave an update on the current situation. The focus was on reducing waiting times and recruitment of trained staff. Progress was outlined in the areas of Eating Disorders, crisis response, community treatment and provision in schools. There had been a 60% increase in referrals to CAMHS and the complexity of cases had increased. Unfortunately, there had been a high staff turnover due to significant levels of stress experienced by the workforce under challenging circumstances. It was noted that there had been significant investment, but there was still a long way to go. The staff needed to respond to the increase in activity during and after the pandemic were not there. The focus was on early intervention, prevention and working with partners.

Councillor Linden raised a concern that GP referrals were being routinely rejected even though they were referring only those most at risk. Louise Noble responded that there were different services for emotional well-being and mental health support and that they try to direct people to the most appropriate service. For example they may be at a 'getting help' level rather than a serious underlying mental health diagnosis. If a referral was sent back it was because another provider would be better for them.

Councillor Moore asked about Mental Health Support Team provision in schools. He noted that not all schools received this support and asked what happened to the remainder. Lajla Johansson advised that this was a national programme of investment from NHS England – the ambition was to cover 25% of schools, but across Berkshire West 50% of schools of schools were covered. It was explained that 100% coverage was not possible at this stage, since teams need university level training. Councillor Moore asked how they choose the schools. Lajla Johansson advised that they used tools to establish the levels of need including data on pupil premiums, deprivation levels and health inequalities.

Councillor Moore asked about the 'challenges' slides in the presentation and whether the colours had significance about ratings. Lajla Johansson confirmed the colours did not signify ratings.

Councillor Macro raised a concern that the waiting times priority was third on the list and asked why it was not higher. He also requested clarity around the terms and acronyms used in the presentation. Lajla Johansson advice that CIC was Children in Care, while B 8/9 related to staff banding levels. She agreed to address this for future presentations. Lajla Johansson confirmed that tackling waiting lists was their highest priority and greatest focus.

The Chairman asked what current waiting times were like in West Berkshire. Louise Noble advised that it varied depending on the referral. The crisis team responded within hours, urgent referrals first contact had slipped from 2 weeks to 6 weeks due to the increase in referrals, and first contact for routine referrals was closer to 12 weeks. The referrals that had a waiting time of 3-5 years were for neurodiversity services rather than specialist mental health services.

Councillor Linden asked about staff turnover and staffing resources. He raised the concern that nationally, staffing had only increased 1% per year over the last 9 years, while demand had increased by around 90% and there was a problem in finding suitable practitioners. He asked if opportunities were being taken to explore other options, such as apprenticeships / bursaries. He also noted that a national survey had highlighted commonplace rota gaps and staff who indicated they were not able to provide the standard of care they would like – he asked if there were similar issues locally. Finally, he asked if local services had enough funding.

Lajla Johansson agreed that the workforce was a recognised problem across the country, but the cost of living in the south east and BOB footprint was an extra factor. It took time to meet the increase in demand as staff needed to be trained. They were looking to: develop a specific children's mental health academy; develop training programmes to skill people up quickly; and to skill up and utilise the third sector to work alongside health professionals. Funding was being made available, but the main difficulty was filling the vacancies.

Louise Noble advised Berkshire Healthcare was the top performing trust on the NHS staff survey and they use that workforce survey at service level to understand what their staff were telling them and what that meant for staff retention and well-being. They were also doing well in terms of the psychiatry workforce. Within the crisis team, they were looking at how they could differently meet needs. For example they were looking at social prescribing, youth mentors and what elements of provision could be met elsewhere. They also have digital provision and were looking at using bespoke digital providers, particularly where they had recruitment gaps / longer waiting times. They also had a programme of work around trainees and apprenticeships.

The Chairman thanked Louise Noble, Lajla Johansson and Duncan Ford for their attendance and contributions.

27 Basingstoke and North Hampshire Hospitals Maternity Services

The Chairman welcomed Alex Whitfield (Chief Executive) Julie Dawes (Chief Nurse) Elliot Nichols (Associate Director Comms and Engagement), Fay Corder (Associate Director Midwifery) and Wendy Landreth (Communications Team Coordinator) to the meeting. The Chairman invited them to present their report on the Maternity Services provision.

The Committee considered a report on Maternity Services at Basingstoke and North Hampshire Hospital (Agenda Item 6).

Alex Whitfield (Chief Executive) introduced the team. She gave apologies for Julie Dawes (Chief Nurse) and introduced Sarah Musset who was coordinating the Care Quality Commission) CQC response on behalf of the Trust. It was noted that the presentation had been requested off the back of the Healthwatch report from a couple of years ago and also on the recent CQC visit where they had made an unannounced visit as a result of which the rating for maternity service had been downgraded from 'good' to 'requires improvement'.

Fay Corder (Associate Director Midwifery) gave the presentation. She advised the Committee of the current maternity service provision from Hampshire Hospitals to West Berkshire women. She then introduced the Healthwatch report, which had highlighted communication as a key concern. The Trust had put a number of measures in place to address this, including improvements to the website and social media, electronic patient information leaflets on Badgernet, and printed complex care plans for women giving birth at other NHS Trusts. She then highlighted the positive feedback from the CQC before covering the should-do's and must-do's from the inspection. She went through a series of slides on the progress made in responding to the key concerns raised in the CQC report, which related to: sepsis; security; emergency equipment; domestic abuse; red flag reporting and risk; learning from incidents, staffing levels; and leadership and culture. She noted that 51 out of 64 actions had been completed. Finally she advised the committee of the main challenges facing the service, progress in terms of Ockenden compliance, and the aspiration to build on changes introduced since the CQC inspection, with the development of QI Plans.

Councillor Alan Macro highlighted the theme of staffing in the CQC report in terms of number of staff, staffing at the appropriate levels and staff working above competency levels and asked for further information on whether the recruitment campaign would be sufficient. Alex Whitfield responded to advise that more midwives were needed for the same number of babies and so they had been chasing a moving target in terms of recruitment. The actual number of midwives had increased, but so had the number of vacancies. However in recent months they were closing the gap through recruitment and retention. The numbers coming in over the next few months would mean that by the autumn they should be where they needed to be.

Councillor Tony Linden noted the Ockenden report and the seriousness of it. He welcomed the progress that had been outlined and the importance of giving assurance to mothers and families associated with the birth experience. He highlighted the higher rates of stillbirth babies for black, Asian and older mothers and mothers from deprived backgrounds and asked how this was being addressed. Secondly he asked if homebirths had been suspended in Basingstoke. Alex Whitfield advised that they did occasionally have to suspend homebirths services because it was safer to bring midwives in. Fay Corder advised homebirths had been suspended for the last two weeks because South Central Ambulance Service (SCAS) had been on Level 4 and so they could not guarantee an ambulance would be available. Fay Corder advised that patients had been ok with that, as they understood the reasons why. Fay Corder then responded to Councillor Linden's first question. She advised that numbers were low in the area and so when they had a sad case of a stillbirth it made the figures look worse than they were. They were working towards the Saving Babies Lives Version 2 Care Bundle and so they put a lot of antenatal surveillance in place – additional scans for growth, public health, quit smoking advice and wrap around health and wellbeing messages. There was also the continuity of care team to help these women throughout the maternity services.

Councillor Moore asked for clarity around the inspection / rating level. Sarah Mussett confirmed that while the Maternity service required improvement, the overall rating for the Trust had not changed. Councillor Moore then asked about how immediate feedback from the CQC happened, as the date of the inspection was 16 November 2021, but it was not published until 28 January 2022. Sarah Mussett confirmed the Trust had initial feedback from the CQC in November and so a significant amount of work had been done before it was published. 54 of the 64 actions had been completed. They had moved quickly with all the improvements, and there had been a huge amount of staff engagement with the improvements at all levels. Some mock CQC inspections had also been carried out.

Councillor Moore highlighted that residents in West Berkshire may go to one of a few hospitals and noted that in the presentation it said that complex care plans were printed for those having babies at Royal Berkshire Hospital. He highlighted anecdotal information, not in relation to Maternity Services, about patients having difficulties with electronic data transfer between hospitals and asked about the difficulties in moving data electronically. Fay Corder said that Basingstoke and Reading did not have the same systems and that they didn't connect. Care plans were printed out and women were able to give it to the hospital. Alex Whitfield confirmed that their systems covered all of Hampshire, but they were clunky across ICS boundaries. Andy Moore asked if there was any medium term solution to this and if there was any directive from NHS England? Alex Whitfield confirmed that there was a desire to share information in a more straightforward way across all services. GP Information was shared more widely. NHS England was setting expectations around ability to share information between systems with standard protocols but not necessarily on the same systems.

The Chairman asked about the main barriers to recruitment and how the mental health needs of midwives were being addressed in order to retain them. Fay Corder advised the Trust was fishing in a really small pond. All maternity units were looking for the next midwife to qualify. The Trust was talking with Winchester University about providing midwife training so that they would have more locally developed midwives. They were also: looking at Maternity Support Worker's going on apprenticeship courses; advertising for return to practice midwives; supporting international nurses doing the midwifery shortened course as a pilot; and meeting with colleges and schools to engage students at an early stage. To answer the second question about midwife mental health they had practice midwifery advocates. They had increased their workforce so that that had training and support for their midwives. They also had a health and wellbeing hub, and a good chaplaincy service. Staff coudl speak to line managers. There was TRIM training avaialble. Also after traumatic experiences staff had external psychologists do debriefing sessions. Sarah Mussett highlighted the specialist midwife roles which provided opportunities for career development and helped with retention. Fay Corder advised of promotion opportunities also.

The Chairman thanked the team for their attendance and presentation.

28 Protocol between the West Berkshire Health Scrutiny Committee and local health bodies

The Chairman advised that the protocol went to consultation. There was a joint response from Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust in support of the protocol and that there have been no objections or amendments. The recommendations were to endorse the final protocol and to recommend the protocol for approval by the Health Scrutiny Committee.

Councillor Moore raised concern that the protocol doesn't have a list of the organisations with whom we are developing the protocol. The protocol should list the bodies and to give an indication of the response from those bodies. There was discussion confirming that we need to an engagement document about the joint requirement to work together and that changes are needed to the protocol. It was agreed that the protocol will be revisited with further guidance from legal before it is voted on. The protocol will come back to the committee at a later stage.

29 Berkshire West Clinical Commissioning Group Update

The Chairman welcomed Belinda Seston and Amanda Lyons from the CCG and asked they provide their update.

Belinda advised that she is the Interim Director of the Place Partnership in place of Katie Summers who is on a secondment. She made the following key updates:

- Hampshire Hospitals are modernising their hospital programme. She is involved in that along with Nigel Lynn. They will consider any wave effects of the new build on West Berkshire residents.
- There has been an access fund to increase GP activity. Additional appointments were made.
- There are conversations around a hospital discharge service. Susan Parsonage, chief executive of Wokingham Borough Council, will be leading on that.
- Dr Tracy Daszkiewicz, Public Health Director for Berkshire West, is taking the lead on the response to the Ukraine crisis. She is being supported by Julian Emms. They are developing a task group.
- Due to covid there has been a significant impact on elective care. The main initiative is to reduce number of patients waiting more than two years. Very soon

there is will no patients waiting over 104 weeks and there will be further work to bring that down further.

Amanda Lyons gave an update on ICB and ICS development. The transition to the ICB as a statutory organisation is subject to royal ascent but they are still working toward 1st July. They have a 12-18 month transition roadmap on both the technical set up of the ICB (the architecture) and are also looking at the developmental areas of the ICS and some of the key enablers.

The ICB architecture looks at the governance between the place-based partnerships and the ICB and the ICP. The ICP being the partnership organisation which includes Local Authority members and the ICB being the NHS statutory body. It also includes that technical and functional integration. It looks at the formation of the board and the how it will interact as the NHS with the region and also taking into account the February Integration White Paper. This is organised and under control for 1 July 2022.

The ICS development aspects are more forward looking. This includes the Provider Collaboratives and the place-based partnerships. They are starting to think through the ICS Strategy and how it fits with Health and Wellbeing Board strategies. What public engagement needs to take place. There are some key enablers which are different to how the CCG's would have functioned. There is real focus on:

- Digital and data – connectivity across the ICS footprint
- Clinical and profession leadership – patient pathways (preventative through to leaving the care of the NHS).
- Diversity and inclusivity of staff and culture. How they tackle inequalities and learning from each other.
- Assurance to give that outcomes are achieved.

Councillor Bridgman welcomed Belinda to the Health Scrutiny Committee. He clarified that Julien Emms is the CEO of Berkshire Healthcare and that Councillor Linden is on the JHOSC for BOB. Councillor Bridgman will be the representative for West Berkshire on the ICP. They are waiting for a working group meeting to be set up on how the ICP operates going forward. They are very interested in the PBP aspect and on where the statutory role of the CCG on health and wellbeing will lie. There will be a role for Scrutiny going forward in relation to BOB and the PBP within it. Councillor Bridgman also noted that the relationship with the CCG and CHC (continuing health care) is on James Kent's list of things to look at.

Councillor Moore asked for clarity regarding the ICP / ICB / ICS and also on Provider Collaboratives. Amanda advised:

- ICB (Integrated Care Board) is the NHS statutory body which will fulfil the statutory responsibilities that the CCG would have previously had.
- ICP (Integrated Care Partnership) is the partnership board which incorporates the Local Authority and other partners. It sits alongside the ICB.
- ICS (Integrated Care System) the umbrella of the ICB and ICP.
- Provider Collaboratives is a terminology which captures any arrangement when one or more NHS body choose to cooperate to deliver something. For example Tier 4 CAMHS. It is not a statutory legal entity and is about how they will work together in partnership.

The Chairman thanked Belinda Seston and Amanda Lyons for their attendance and their updates.

30 Healthwatch update

The Chairman noted the reports in the pack. No update was given.

31 Task and Finish Groups

The Chairman asked Members to consider the proposed Terms of Reference for the Continuing Health Care Task Group. To agree membership, the Chairman and a timescale.

Councillor Bridgman advised that this is on James Kent's radar. Councillor Bridgman has made it clear that we are not happy with how West Berkshire comes out under CHC. We are not working the same as Oxford. There are different matrices which lead to different financial end points. There is a conversation to be had with the CCG and what will become the place-based partnership. Belinda Seston said that she will go back and look at it. Amanda advised that from a system level that James Kent is sighted on these conversations and she will take it back also.

It was agreed that the Task and Finish Group will begin with this in mind. The Chairman advised that membership has been discussed and Councillor Beck, Councillor Moore, Councillor Linden and Councillor Macro will be on the Task Group. Councillor Macro will be Chairman and Councillor Linden will be Vice-Chairman. The timescale can be agreed at the task group meeting.

32 Health Scrutiny Committee Work Programme

The Chairman asked for any comments on the work programme.

Councillor Macro asked for the Facilities for New Developments to be moved forward because the Local Plan is being updated and it is an important factor for residents when new developments are proposed. The Chairman agreed we can look at moving it up the schedule. The motion regarding the re-development of RBH was raised by Councillor Moore and agreed it will be discussed at the next meeting.

(The meeting commenced at 1.30 pm and closed at 4.02 pm)

CHAIRMAN …….

Date of Signature …….

DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON TUESDAY, 10 MAY 2022

Councillors Present: Claire Rowles (Chairman), Alan Macro (Vice-Chairman), Gareth Hurley (In place of Jeff Beck), Tony Linden and Erik Pattenden (In place of Andy Moore)

Apologies for inability to attend the meeting: Councillor Jeff Beck and Councillor Andy Moore

PART I

1 Election of the Chairman

RESOLVED that Councillor Claire Rowles be elected Chairman of the Health Scrutiny Committee for the 2022/2023 Municipal Year.

2 Appointment of the Vice-Chairman

RESOLVED that Councillor Alan Macro be appointed as Vice-Chairman of the Health Scrutiny Committee for the 2022/2023 Municipal Year.

(The meeting commenced at 8.34 pm and closed at 8.36 pm)

CHAIRMAN …….

Date of Signature …….

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Health Scrutiny Committee – 14 June 2022

Item 3 – Declarations of Interest

Verbal Item

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Health Scrutiny Committee – 14 June 2022

Item 4 – Petitions

Verbal Item

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Elysium Healthcare No.2 Limited

Thornford Park

Inspection report

Crookham Hill
Thatcham
RG19 8ET
Tel: 01635860072
www.elysiumhealthcare.co.uk

Date of inspection visit: 14 & 15 September 2021
Date of publication: 08/12/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Thornford Park is a 129 bedded hospital providing inpatient medium and low secure forensic mental health services including a ward for people with learning disabilities and a ward for people with autism. It also has two psychiatric intensive care units (PICUs) and three rehabilitation flats.

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

- There were high nursing vacancy rates at the service. The hospital utilised agency staff to fill these gaps, however this was not always possible. This meant that the wards were sometimes short-staffed and on the forensic wards this had an impact on patients being able to take leave. This had an impact on patient's wellbeing and could impact on their recovery. At our previous comprehensive inspection in 2017 we told the hospital it must make improvements to ensure it always has enough appropriate staff to meet patients' needs; this was, and remains a breach of the Health and Social Care Act regulations.
- Governance and oversight processes at the hospital required improvement. The quality of care records on the forensic and PICU wards was variable. Kingsclere ward had very thorough and comprehensive records, while records on Bucklebury ward were less personalised and did not include adequate mitigation plans for identified risks. Care records did also not reflect the patient voice.
- The forensic wards looked very tired and required refurbishment. These were due to be renovated, with a programme of works due to commence in 2022.
- Staff utilised the National Early Warning System (NEWS 2) to monitor the physical health of patients. However, on the forensic and PICU wards it was not always documented what action had been taken when indicated which meant that the physical health needs of patients may not have been acted upon, placing them at risk.
- Some patients on Bucklebury and Hermitage wards told us they did not feel safe due to the risk of violence from other patients. Violence and aggression was the most common incident type reported on the wards.
- On Headley ward a patient had two T2 forms signed by two different approved clinicians in place authorising different medicines (a T2 form confirms that a patient is capable of understanding the nature, purpose and likely effects of a treatment and that they have consented to receiving this). This could have led to a patient receiving the wrong medicine, or not receiving medicine they should have.
- On Curridge ward we found that a defibrillator wasn't working. This had not been identified because the relevant audits of emergency equipment had not been carried out.
- Patients on the PICUs told us that there were not enough activities to occupy them during evenings and weekends.
- Staff on the PICUs did not always receive regular individual supervision. Compliance rates for individual supervision in the quarter prior to the inspection were 68%.

However:

- The learning disability and autism wards were rated as good overall. Staff demonstrated a commitment to providing person-centred care for patients and we saw some excellent use of communication methods.
- Staff had handled the COVID-19 pandemic very well. None of the patients at the hospital had tested positive since April 2020.
- The senior leadership team had a good understanding of the key challenges the service faced. The hospital director was a visible presence throughout the hospital and approachable for patients and staff.
- The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP).

Summary of findings

- Patients we spoke with gave excellent feedback about the way staff treated them. They said they were always kind and compassionate.
- Patients were involved in their care and developments in the hospital. There was a patient council made up of representatives from each ward and patients also attended ward-based and hospital-wide clinical governance meetings.
- Staff were supported to develop in their roles. For example, all ward managers were able to complete level five leadership training.
- The hospital had robust safeguarding procedures in place. Staff had good knowledge of these procedures and the provider had supported 11 staff members to complete level four safeguarding training.
- Patients had good access to physical healthcare and were supported to make healthy lifestyle choices, e.g. offered nicotine replacement therapy and weight management programmes. The hospital also had an onsite gym and ran exercise classes to encourage patients to exercise.
- Staff had recently begun hosting a monthly online carers' forum which provided an opportunity for carers to learn more about the hospital.

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 	Our rating of this service went down. We rated it as requires improvement because: • The environment on Curridge ward was stark and the layout of the communal area was untherapeutic, with furniture all pushed to the sides. • There were two lead nurses which were shared across the forensic and PICU wards, however we found a number of inconsistencies in how things were done on the PICU wards. Leaders had recognised this and a PICU lead nurse was due to start in post shortly after the inspection. Their focus would be on improving standards on these wards. • Staff were unaware of the provider's restrictive practice policy and did not understand why some behaviours would be perceived as restrictive practice. • Staff did not always follow the procedures that were in place to ensure that medicines were safely prescribed, administered, recorded and stored. • Care plans on the wards were generic and did not reflect the involvement of patients in the development of their plans. • There were insufficient activities on the wards to provide meaningful, therapeutic engagement for patients to support their path to recovery. • Staff on the PICUs did not always receive regular individual supervision. Compliance rates for individual supervision in the quarter prior to the inspection were 68%. • Governance processes did not operate effectively at ward level. However: • Staff assessed and managed risk well. • Staff had a good understanding and knowledge of safeguarding procedures.

Summary of findings

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.

Forensic inpatient or secure wards

Requires Improvement

Our rating of this service went down. We rated it requires improvement because:

- The wards looked very tired and required refurbishment. A programme of works was due to begin in 2022.
- There was generally enough staff on the wards to keep people safe, but not enough staff to ensure that patients could always take planned leave from the ward. All of the patients we spoke with told us they had leave cancelled.
- The quality of care plans was variable across the wards and some care plans were generic and not reflective of individual patient needs.
- We found that governance processes required improvement – we found issues with treatment authorisation forms and ligature audits that had not been picked up by the provider's own quality assurance processes.

However:

- Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Ward managers had a good understanding of patients' needs. They knew the patients well.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, patients rarely had their discharge delayed for other than a clinical reason.

Wards for people with learning disabilities or autism

Good 

This was the first time we rated this service. We rated it as good because:

- The care provided to patients was of a very high standard.
- Ward managers had an excellent understanding of their services and of patients' needs. They were visible and approachable for patients and staff.
- Care plans, risk assessments and Positive Behavioural Support (PBS) plans were clear and informative.
- Individual needs were met and staff demonstrated skill and kindness. Patients said that they were listened to, could ask for help, were able to participate in their care plans and planning their future. Staff helped them achieve their goals and supported them to make decisions.
- Patients stated they were happy with their care and treatment and the support offered.
- Staff were confident in being able to express their thoughts and on the whole felt really well supported by the ward managers. They felt they were given opportunities to improve their skills and develop.
- The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP).
- Staff ensured physical health was well monitored and documented.
- Discharge plans were discussed and documented as achievable goals for individuals' needs.

Summary of findings

- Staff used verbal de-escalation to manage patient incidents and there was low use of restrictive interventions.

However:

- Some staff on Tadley ward felt that they were not supported by senior staff following incidents, that there were no senior management staff at the debriefing sessions to discuss the management and outcomes of incidents.
- Staff on Tadley ward were unable to locate the ligature audit for the ward.
- High fridge temperatures had been recorded on Tadley ward, however no action had been taken to address this.

Summary of findings

Contents

Summary of this inspection

Background to Thornford Park

Thornford Park is a 129 bedded hospital providing inpatient medium and low secure forensic mental health services including a ward for people with learning disabilities and a ward for people with autism. It also has two psychiatric intensive care units and three rehabilitation flats which can accommodate up to eight patients. A full breakdown of the wards is provided below:

- Bucklebury, 12 bedded male acute medium secure unit
- Tadley, 10 bedded male medium secure unit for people with a learning disability
- Hermitage, 14 bedded male rehabilitation medium secure unit
- Kingsclere, 13 bedded male rehabilitation low secure unit
- Donnington, 14 bedded male low secure unit for people with autism
- Headley, 11 bedded male acute low secure unit
- Highclere, 17 bedded male low secure unit for older people
- Theale, Nine bedded male enhanced low secure unit
- Crookham, 11 bedded male psychiatric intensive care unit
- Curridge, 10 bedded female psychiatric intensive care unit
- Midgam, Two bedded male low secure flat
- Ashford, Five bedded male low secure flat
- Donnington Flat, One bed male low secure flat for people with autism

Thornford Park is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the MHA
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

There was a registered manager in post at the time of the inspection.

We had previously inspected the service in November 2017. Following this inspection the service was rated good overall, with the responsive key question rated as requires improvement. Following this inspection in 2017 we told the provider it must make the following improvements: The provider must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients as patients did not always have facilitated escorted leave or access to enough therapeutic activities to meet their needs and support their recovery journey.

We found that this issue remained at this inspection.

In June 2020 we carried out a focused inspection of Curridge (female PICU) and Tadley (male medium secure unit for people with a learning disability). This was due to concerns raised about the quality of care delivered to patients and about the increasing number of incidents that the provider had sent us notifications about alleged abuse and significant injuries. We did not re-rate this service following this inspection. However, we told the hospital it must take action to:

- Ensure records were up to date and accurate so staff could mitigate risk and meet the changing needs of patients.

We found that this issue remained at this inspection.

Summary of this inspection

What people who use the service say

Patients on the forensic wards told us that staff treated them well and that the wards were clean. All of the patients we spoke with told us that there are not enough staff on the wards and that they sometimes have their leave or planned activities cancelled as a result of this. However, patients told us that while there are not enough staff, the staff who are there are kind, attentive and respectful. Patients we spoke with on Kingsclere ward told us they felt safe at the hospital, however patients on Hermitage and Bucklebury wards said they did not always feel safe due to patients assaulting other patients.

Patients on the PICUs told us that there were limited daily activities offered and the timetable that was provided did not meet their needs in terms of the limited range of activities available and the lack of structured activities in the evenings and at weekends. Patients understood that the recent Covid-19 pandemic had affected their ability to attend occupational therapy led group work and were looking forward to new opportunities becoming available.

Patients on the learning disability and autism wards told us their rights were respected and they understood their rights of appeal. They told us the ward manager was on the ward most of the time. They said they had daily meetings with staff and their comments were taken seriously and action taken on issues they requested. Patients stated they felt safe, and although incidents occurred, staff responded quickly to these and they felt safe.

Some concerns were raised about there not being enough staff all the time, but most of the time there were staff they knew, just sometimes they didn't feel too confident with the agency staff as it takes time to get to know them and trust them.

The people we spoke to said they were happy with their environment and were allowed to personalise their rooms. They also said they were given easy read paperwork if they needed or asked for it and that they felt involved in their care.

Patients on Donnington ward said that they didn't like it when staff shone a torch in their room at night but understood why it was done. They have discussed this at a meeting with staff and this is now being looked into to find an alternative approach to checking patients at night.

How we carried out this inspection

The team that inspected the hospital comprised the head of hospitals inspection for the region, an inspection manager, six inspectors, five specialist advisors and three experts by experience.

Before the inspection visit, we reviewed information we held about the hospital.

During the inspection visit, the team:

- Visited all of the wards and communal areas within the hospital to review the environment and observe how staff were caring for patients
- Observed a variety of meetings including a site business meeting, risk management meeting and ward rounds
- Spoke with 20 patients
- Spoke with four relatives

Summary of this inspection

- Spoke with members of the senior leadership team including the hospital director, deputy hospital director, medical director, director of nursing, director of allied health professionals, director of support services, lead psychologist and lead nurses
- Spoke with 33 other staff including nurses, occupational therapy assistants, healthcare assistants, consultant psychiatrists, ward managers, deputy ward managers, occupational therapists, nurse associates and social workers
- Reviewed four Human Resource files
- Reviewed 48 care records and 38 medicines charts
- Looked at a range of policies, procedures and other documents in relation to the running of the service.

Outstanding practice

We found the following outstanding practice:

- Donnington ward demonstrated some excellent practice in managing communication with people who have autism, they had a variety of communication aides on the individuals' room doors to enable staff to understand how individual patients were feeling that day, ensuring that risk minimisation was first and foremost combined with the individuals wants and needs.
- The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP) which involved patients on Donnington ward and was presented by therapists and ward staff.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that there are sufficient staff to facilitate leave for patients on the forensic wards (Regulation 18 (1)).
- The provider must ensure it consistently manages supervision on the PICUs (Regulation 18 (2) (a)).
- The provider must ensure that care records on the forensic and PICU wards are of a consistently good quality and that they include the patient voice. There must be clear mitigation plans in place for any identified risks. (Regulation 17 (2) (c)).
- The provider must ensure that there are robust systems in place to ensure it is clear for staff which medications have been authorised for patients on the forensic wards (Regulation 17 (1)).
- The provider must ensure that on the forensic and PICU wards it is consistently recorded what action has been taken when it is indicated that a NEWS2 score should be escalated (Regulation 17 (2) (c)).
- The provider must ensure that emergency equipment audits are put into place and carried out on Curridge ward (Regulation 17 (2) (a)).
- The provider must ensure that the reducing restrictive practices policy is followed and understood by the staff teams on the PICU wards (Regulation 17 (2) (a)).
- The provider must ensure that a range of therapeutic activities is available to meet patients' needs in the PICUs in accordance with guidance from the National Institute of Health and Care Excellence (Regulation 9 (1)).

Action the service SHOULD take to improve:

Summary of this inspection

- The provider should ensure that the garden areas are well maintained, including ensuring that any loose flagstones are secured to reduce the risk of accidents (Regulation 12 (2) (d)).
- The provider should consider alternative systems for key management, to ensure that staff can access equipment promptly when needed (Regulation 12 (2) (d)).
- The provider should ensure that there are regular staff meetings happening on Crookham ward (Regulation 18 (2) (a)).
- The provider should ensure that the local clinical governance structure on the PICU wards identifies actions with timeframes for completion (Regulation 17 (2) (a)).
- The provider should ensure that staff are aware of where to find the ligature audit on Tadley ward (Regulation 12 (2) (b)).

Our findings

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	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

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

Requires Improvement

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

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

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

Crookham ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Curridge ward environment was clean but the environment was older and damaged due to the high acuity of the patients. On Curridge ward clinical room checks and audits were not being carried out regularly.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all ward areas and removed or reduced any risks they identified. We saw completed ligature risk assessments and there were enough staff to observe patients in all areas of the wards.

The wards complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff were familiar with the wards ligature risk assessments and ward managers or their nominated deputy knew where the high risk ligature points were.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were checked and managed by the reception area and there were checks in place to ensure that all alarms were charged and working.

In the airlock onto Curridge ward there was a staff toilet which was normally left unlocked. The toilet was found to have COSHH (Control of Substances Hazardous to Health) cleaning materials on the shelf which were a risk if a patient managed to push passed staff and access this area. We addressed this immediately with the ward manager who ensured that the room would remain locked and a sign was put up. This issue was not identified on the ward daily environmental checklist.

Maintenance, cleanliness and infection control

On Crookham the ward area was clean, well maintained, well-furnished and fit for purpose. The ward environment on Curridge was older and in need of updating to match the environment on Crookham. The fixtures and fittings on

Curridge were well worn and the environment was stark and untherapeutic. It was unclear whether the five year renovation and improvement plan for the hospital would mean all the wards would be brought up to the same specification that some parts of the hospital had been upgraded to or whether this was just to undertake general, more basic updating and maintenance.

Staff across both wards followed infection control policy, including handwashing and it was evident that additional infection control procedures had been introduced in order to manage the spread of Covid 19.

Seclusion room

The seclusion room available to Crookham ward was just outside the ward environment and met the environmental criteria for seclusion as described in the Mental Health Act Code of Practice.

The seclusion room on Curridge ward was occupied at the time of the inspection which meant we were unable to fully inspect it. Within the three months prior to the inspection there had been 17 epidodes of seclusion on Curridge ward. In five of these episodes patients from Curridge ward had been secluded elsewhere due to the seclusion suite already being occupied.

Clinic room and equipment

The clinic room on Crookham ward was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic room checks were happening and staff maintained and cleaned the equipment.

On Curridge ward the clinic room was equipped with accessible resuscitation equipment but at the time of the inspection there were no regular checks and audits of clinic room equipment happening. The ward manager had not reallocated the responsibility for this when the previous responsible person had left the ward. The defibrillator was found to be out of use as the battery had expired and this had not been picked up by ward audits. This was addressed with the lead nurse and a new defibrillator was put on the ward during the inspection. The issue of no clear oversight of clinic room audits had been identified by the organisation in a “dealing with medical emergencies audit” carried out in March 2021. The actions identified in the audit were to “establish and develop a formal system” but this had not been completed at the time of the inspection.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received training to keep people safe from avoidable harm.

Nursing staff

The service used locum agency staff who were familiar with the wards and knew the patients well, to fill vacancies. The PICU wards had a total of four registered mental health nurse vacancies and 8.7 support worker vacancies. Managers told us that ongoing recruitment was happening in order to fill the vacancies. The staffing issue was identified on the hospital risk register as an amber risk and was being reviewed monthly by the senior management team.

The ward manager on Curridge was able to adjust staffing levels according to the needs of the patients. On Crookham there was no ward manager in post and the ward was being overseen by a lead nurse who was able to make adjustments to the rota dependent on patient needs. The ward manager post had been vacant since February and the hospital was in the process of recruiting to the position.

Staff knew which incidents to report and how to report them. Managers debriefed and supported staff after any serious incidents. Staff told us that the senior management team offered debrief opportunities if needed.

Patients reported that there were not always enough female staff on Curridge ward to support the 1:1 and 2:1 staffing requirements. During the inspection we observed this, with one female patient almost completely supported by two male staff members at all times during the day. This meant that it was difficult for the patients' needs to always be met when required as staff had to be swapped around within the hospital to maintain this need and could pose a risk to the privacy and dignity of patients. Managers told us that female staff would be assigned to observe patients during personal care and would also be assigned if this was a need identified within their care plan.

Medical staff

For each of the PICU wards the consultant psychiatrist was shared with one other ward. The wards had speciality grade doctors working under the consultants. On Curridge there was also a nurse practitioner, but this was not the case on Crookham.

Managers could call locum medics when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Out of hours the hospital operated with a first and second on call system. The first on call was the nurse practitioner and the junior doctors and then if additional support was required the second on call were the consultants on a rotation.

Medical cover was provided by a GP who attended the hospital and patients on Crookham could access the weekly GP clinic. The on-call GP would attend if required.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. Information provided by the hospital identified that figures for the whole hospital were good.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission. Basic risk assessments were in place across the two wards. Staff updated risk assessments regularly.

Hospital wide clinical governance meeting minutes indicated that during June the hospital as a whole had no incidents of prone or supine restraint that exceeded 10 minutes.

Staff carried out patient risk assessments using recognised risk assessment tools, which included historical information as well as short-term assessment of risk and treatability. Staff included factors which protected patient's wellbeing.

Management of patient risk

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff could observe patients in all areas across both wards.

Staff followed the organisation's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were not being effectively monitored and managed across the wards. On Curridge ward the staff were aware the organisation had a reducing restrictive practices monthly meeting but were not aware of any changes that had been made or were being monitored as a result of this monthly meeting. Staff were not aware of a reducing restrictive practices policy.

Staff could not always identify restrictive practices and it was perceived as something that was in the process of being reviewed. This meant there were many restrictive practices that were in place that were not being reviewed to see if they were still necessary. For example, patients did not have access to keys to their rooms or lockable storage in their rooms they could access. Most internal doors were locked, including access to the laundry and de-escalation rooms. Staff locked the laundry rooms due to them containing high risk items. Patients could request access from staff at any time. The gardens on both wards were open during daylight hours and accessible with staff at night.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patient restraints and seclusion were being reviewed on every ward by the monthly reducing restrictive practices meeting.

Safeguarding

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.

Both the wards had identified safeguarding leads who ensured that if a safeguarding issue was identified that the correct investigation was carried out and reported to the local authority when required.

Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had face to face training in safeguarding adults and children in their induction and then used e-learning modules to ensure they were up to date. Across the hospital 85% of staff were up to date with safeguarding training level one and 85% of staff were up to date with safeguarding training level two.

Ninety one percent of staff had also completed training in Prevent, which is training designed to support vulnerable people from engaging in any threat from terrorism.

Staff access to essential information

Staff had easy access to clinical information but they did not always maintain high quality clinical records.

The quality of the clinical records was variable across the two wards. We reviewed eight sets of patients' electronic notes and found the daily notes were comprehensive and detailed the patient's presentation for the shift. However, the four sets of care plans we looked at on Crookham were not holistic and at times were generic. Care plans on Crookham ward did not include the patients voice or involvement and lacked input from occupational therapists and psychologists.

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

Requires Improvement

Medicines management

The service had systems and processes to safely prescribe, administer, record and store medicines however these systems were not always followed. Staff did not regularly review the effects of medications on each patient's mental and physical health.

We reviewed 16 patients' medicines records and saw that staff mostly followed the correct procedure and practices for prescribing and administering medicine. The hospital used an external pharmacy company to audit and advise the clinicians and the clinical governance team on the safe management of medication, however this may not have been effective as we found a number of issues across the wards. Out of the eight medicine cards we reviewed on Curridge ward we found one card had signature omissions and one of the cards had not been dated by the prescriber. Three of the medicine cards had had more than one antipsychotic prescribed and where the dosages exceeded the BNF (British National Formulary) limits there were no high dose antipsychotic therapy forms in place. We were told that the forms were due to be completed at the next ward round. One of the patients was receiving Lithium and Clozapine treatment, the clozapine monitoring was in place however the Lithium monitoring was not in place. The nurse practitioner put this into place during the inspection to ensure it was addressed.

The wards had two clinic rooms that had the relevant equipment. On Curridge ward the recording of the emergency equipment was sporadic, the last weekly check recorded was over a month prior to the inspection. We were told that the nurse in charge of the checks had recently changed their hours and it had not been reallocated at the time of the inspection. The defibrillator on Curridge ward was showing a red cross in the window indicating it was not able to be used. This had not been picked up as the checks had not been reallocated. The hospital had a number of new defibrillators and a new one was brought to the ward on the day of the inspection.

Room temperatures and fridge temperatures were recorded and audited regularly. The clinic rooms all had labelled containers for the safe disposal of medicines which was signed for securely by two nurses.

The hospital had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The service used a system for monitoring escalations in physical health related issues for all patients called NEWS2 (National Early Warning Score 2). Some staff across both wards were confused with where the NEWS2 forms should be kept. Some staff stated they should be kept with the medication cards and some staff believed they were held in a separate folder. When we located the NEWS2 forms we found NEWS2 forms were present for all patients however some recordings were not scored and where scores had indicated an escalation, the correct escalation procedures had not been followed.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents, but not all staff felt that the managers shared the lessons learned.

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

Requires Improvement

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

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

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were holistic and recovery-oriented.

We reviewed eight sets of care records and found care plans were variable across the two wards. Some of the care plans on Crookham ward did not always reflect patients' assessed needs and the patients voice. The care plans were prescriptive and generic detailing what the staff would do to the patient and not how patients and staff would work collaboratively.

Audits of care plans were carried out on both wards and fed back to the managers or nominated deputy in managerial supervision. Some patients we spoke to told us that they did not feel involved in their care planning, and some did not know they had a care plan.

The service utilised an electronic patient recording system called care notes to record and store patient correspondence. This system ensured safe storage of personal information.

Best practice in treatment and care

Staff did not fully provide a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes.

Staff delivered a very brief occupational therapy activity program of two sessions a day Monday to Friday during the day, this was not in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend meaningful and culturally appropriate activities seven days a week and not limited to 9am to 5pm. Occupational therapy staff told us that this was under review. At the weekends activities were allocated to ward staff to do such as one session of table tennis for Saturday but this was not always carried out due to staff availability. Patients felt that there was not enough to do to engage them.

Staff made sure patients had access to physical healthcare, including specialists as required. A GP visited the hospital twice a week and patients were able to visit the main hospital building for appointments.

The wards had limited psychological interventions which were based on patient need. A permanent psychologist worked on Crookham ward, with support from an assistant psychologist one day per week. A locum psychologist worked on Curridge ward, however a permanent candidate had recently been appointed. An assistant psychologist also worked on the ward full time. The input was mostly formulation work and little input of psychological interventions was evident from reviewing the patient care plans.

Staff used recognised rating scales, such as the Health of the Nation Outcome Scale (HONOS) to measure patients' progress on the unit.

Skilled staff to deliver care

The ward teams had access to specialists required to meet the needs of patients on the wards. The ward manager and lead nurse supported staff with appraisals, ad hoc supervision and some opportunities to update and further develop their skills.

A psychiatrist was allocated to each ward, in addition Curridge had a nurse practitioner supporting the psychiatrist and Crookham had a junior doctor.

Staff attended reflective practice sessions with a psychologist twice a month. Staff did not always receive individual supervision. Data showed that supervision compliance rates were 68% in the quarter prior to the inspection.

The managers would try to catch up with the staff members once a month but we were told formal managerial supervision was not happening regularly.

Mandatory training was managed off the ward by the training department. When required they would contact the managers who completed the rota and staff were allocated sessions to attend training. The staff also had access to the "Good Practice Hub" which had a library of additional training subjects such as: autism training and trauma informed care training.

Multi-disciplinary and interagency teamwork

Staff worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held weekly multidisciplinary ward round meetings to discuss the patients.

The hospital had a contract with an NHS trust and a number of beds on Curridge ward were specifically allocated to patients only from this trust. The staff worked closely with this trust to manage the beds and environment, through regular calls and meetings.

Staff shared information about patients and any changes in their care, during handover meetings. These meetings had a clear structure and the minutes were recorded on the electronic notes system.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Informal patients knew that they could leave the ward freely, but we did not see any information or posters on the wards informing them of this.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. Patients had easy access to information about independent mental health advocacy. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it in the patient's notes each time.

Mental Health Act training was part of the mandatory training for all staff. This was currently online training. At the time of the inspection 82% of staff on Curridge and 90% of staff in Crookham had completed this.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

Requires Improvement

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and staff on both wards recorded capacity to consent to treatment clearly for patients who might have impaired mental capacity. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

We found the recording of capacity to consent to treatment on both wards was completed on admission.

Mental Capacity Act training was part of the mandatory training for all staff. This was currently online training. At the time of the inspection 65% of staff on Curridge and 80% of staff on Crookham had completed this.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff were warm, showed a genuine interest in patients' wellbeing and respected patients' privacy and dignity. Staff used effective de-escalation skills to manage conflict well and with confidence. Patients told us that staff were kind.

Carers we spoke with said that staff were very respectful, caring and kept them informed.

Involvement in care

Patients did not feel involved in care planning and risk assessment but the wards actively sought their feedback on the quality of care provided through regular patient meetings on the ward. They ensured that patients had easy access to independent advocates.

Involvement of patients

Some patients we spoke to told us that they did not feel involved in their care planning, and some did not know they had a care plan. Most patients told us that they had not received copies of their care plans.

Patients could give feedback on the service and their treatment and staff supported them to do this through the weekly community meeting.

Staff made sure patients could access advocacy services. Advocates visited the wards each week. The advocates would ring the wards weekly to find out if there had been new admissions or discharges.

We saw "you said, we did" boards on the wards but these were not being used at the time of the inspection and had historic information on them.

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

Requires Improvement

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers told us they felt welcome at the weekly ward round. Staff told us that they had regular contact with families and carers. Staff actively sought patient consent to share information with relatives before sharing information. Patients told us that their families and carers were involved in their care.

The service used video calling during Covid-19 pandemic restrictions, when visiting was not allowed.

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

Good

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

Access and discharge

Staff managed beds well. A bed was available when needed. Staff told us that some patients' discharge was delayed due to non-clinical reasons.

Bed management

Staff managed beds well. Curridge ward had a contract with an NHS trust which commissioned their beds. Crookham ward took referrals from all over the United Kingdom. The manager on Curridge felt very involved in the referral process and was able to review the appropriateness of referrals into the PICU in line with national guidance.

Managers and staff worked to make sure they did not discharge patients before they were ready. We were told the average length of stay in the PICU wards was three to four weeks.

When patients went on leave there was always a bed available when they returned.

Discharge and transfers of care

There was only one patient who had their discharge delayed from Curridge and this was due to availability of a suitable placement in the patient's local area. Managers monitored the number of instances where patients' discharge had been delayed.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity; however, patients did not have keys to their rooms. Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy but these areas were normally kept locked to maintain the safety of the ward.

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

Requires Improvement

Patients did not have their own keys for their bedrooms. All the bedroom doors were self-locking and needed a staff member to unlock the door. Patients told us that they felt the ward was too restrictive and they were unhappy with not having a key to their bedroom. Patients did not have lockable storage in their room that they could access. Patients had a small locker on each ward, that contained high risk items. These were in the ward corridors and only accessed by the ward staff.

The hospital had quiet areas and a room where patients could meet with visitors in private. Patients could meet with visitors in rooms located at the reception of the hospital. However, the quiet room and de-escalation room on both wards were behind a locked door.

Patients on both wards could access the gardens during daylight hours. Patients could access the garden with staff at night.

Patients had access to a multi-faith room.

Patients could ask staff to make them hot drinks whenever they wanted. Patients could ask staff for snacks throughout the day. The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that they liked the food and were given choices.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they could access translation services when needed. On Crookham ward, staff had requested to use online translation services for the everyday needs of patients whose first language was not English.

Patients could make phone calls in private. Patients also had access to their own mobile phones.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. Information was provided to patients in their welcome pack upon arrival. Staff knew how to handle complaints sensitively.

If a complaint could not be resolved, this was escalated to the unit manager. We saw evidence of complaints that had been responded to.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

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

Requires Improvement

Requires Improvement

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

Leadership

Leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The hospital director was a visible presence throughout the hospital. Staff told us that other members of the senior leadership team were less visible on the wards but that they were contactable if needed. The director of nursing was relatively new in post and still developing into her role, her team and the vision and direction for nursing.

The senior leadership team had a good understanding of the key challenges the service faced. They were focused on improving recruitment and retention to improve the service for both patients and staff. The provider had worked to develop career progression pathways for staff at all levels to try and improve retention. The hospital director was also working with the group Human Resources director on a project to improve staff recruitment and retention.

Leaders were supported to complete leadership training. For example, the hospital's director of nursing was completing level seven leadership training and some of the ward managers were completing level five. Completion of the training required staff to complete a project which was then used to improve practice at the hospital. For example, staff were completing projects around how to improve the induction for healthcare assistants and least restrictive practice.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Most staff felt respected, supported and valued within their teams. Staff spoke about there being different organisational cultures across the two wards, with Crookham processes more embedded and staff understanding their roles and responsibilities. Staff felt Crookham ward was more settled and organised despite not having a full time ward manager at the time of the inspection. Staff told us they could raise any concerns to the ward manager on Curridge without fear but did not always feel that they were able to make changes to the running of the wards.

We saw some disconnect between the senior nursing management team and the ward team around decisions taken. Senior managers felt that systems and processes such as the reducing restrictive practices and NEWS2 systems were embedded and functioning but this was not reflected at ward level.

At the time of our inspection, managers told us no grievance procedures were being pursued within the wards and there were no allegations of bullying or harassment.

Staff were aware of the whistleblowing process if they needed to use it.

Staff felt there was a heavy reliance on agency staffing and this sometimes made established staff feel undervalued.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that organisational processes were not always managed well.

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

Requires Improvement

Staff on the wards told us they were not receiving regular supervision, the ward staff were not always aware who their supervisor was and when they were next due supervision. On the wards there were not always records of supervisions and the online matrix was not up to date.

Safe staffing levels were monitored on a shift by shift basis using a recognised safe staffing tool.

There were no regular staff meetings taking place on Crookham ward. Staff on Curridge ward had attended three team meetings within the last four months. Although staff could give feedback or raise concerns directly with senior leaders via different mechanisms including staff open forums, there was no clear and consistent way of capturing and escalating feedback and concerns from the ward staff teams.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of a national population.

Issues such as the checking of emergency medical equipment had been highlighted in the audit "dealing with medical emergencies" in March 2021 on Curridge ward and actions had been identified to address this, however these had not been followed up and this had led to the defibrillator not being regularly checked.

Management of risk, issues and performance

There was a clinical governance structure in place with local meetings happening to ensure information and risk was discussed. We reviewed six sets of local clinical governance minutes and we could see that these issues were identified however actions were being allocated without timeframes for completion and were not being picked up in the following meetings actions arising so we were not reassured they were always being addressed and completed.

Information management

The ward manager and the lead nurse had systems and dashboards in place to support them in their roles. This included information on staffing, supervision and appraisals, training and hospital performance data. It was not clear how these were used at ward level to inform the clinical and managerial supervision processes.

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Good

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

Safe and clean care environments

All wards were safe, clean, well equipped and fit for purpose. The ward décor was tired.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff completed weekly environmental checks of all ward areas and were required to document any required actions for escalation to the maintenance team. The ward manager then signed this off once all outstanding actions had been completed. However, staff on Highclere ward stored equipment such as wheelchairs and a hoist in one of the corridor areas. This meant that patients could not access the handrail along the corridor and presented a falls risk. We told staff about this during the inspection and the obstructing items were removed. Bedroom doors had anti-barricade fittings and staff had recently carried out audits to check that these were in a good state of repair and that staff knew how to use them. The audits highlighted some gaps in staff knowledge around how to use these and that some of the doors on Theale ward had been installed incorrectly. These issues had been reviewed within the site governance meetings and an action plan was in place to address the findings. One of the bedrooms on Highclere ward did not have an anti-barricade fitting. This room was vacant at the time of the inspection and we were told that a risk assessment would be carried out prior to a patient being allocated the room.

Staff could observe patients in all parts of the wards. Some of the wards had blind spots at the end of corridors, however these were mitigated with the use of mirrors and staff observation.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers had completed ligature audits for all wards and communal areas within the last 12 months. Where ligature anchor points were identified there was a documented plan in place for how to manage these. However, we found that on Hermitage

ward there were some ligature points in the garden that had not been included on the ligature audit. Staff we spoke with were aware of ligature heat maps on their wards, which showed where the high risk areas were. Some of the en-suite bathrooms on Headley and Theale wards did not have anti-ligature fittings, however patients were risk assessed prior to being placed in those rooms and there was a programme of works due to start to replace them.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff carried an alarm and a radio. Patients had access to call buttons in their bedrooms and bathrooms.

Maintenance, cleanliness and infection control

Ward areas were clean and fit for purpose, however not always well maintained. We found the ward areas to be tired and in need of refurbishment, with stains on the walls and marks on the floors. Managers told us that there was a five year plan for site renovations, with improvements to the environment on Kingsclere, Theale, Highclere, Headley and Bucklebury wards to take place in 2022. However, it was unclear whether this would bring all the wards up to the same specification that some parts of the hospital had been upgraded to or whether this was just to undertake more basic updating and maintenance. When we visited Bucklebury ward we observed there were some loose cables hanging out from a broken light switch on the wall. We raised this with managers who agreed to review and address this. On Headley ward there had been a shower leak and so the wall was stained with dirty water marks. We found the garden areas on Theale and Headley wards were not well maintained. There were some loose and unlevel flagstones in the garden on Kingsclere ward which could put patients and staff at risk of tripping.

Staff made sure cleaning records were up-to-date and the premises were generally clean. Housekeeping staff cleaned patient bedrooms once a week. Patients were encouraged to keep their rooms clean and tidy in-between.

Staff followed infection control policy, including handwashing. Staff had managed infection control throughout the Covid-19 pandemic very well, with no patients testing positive for the virus since April 2020. Staff completed regular cleaning of high touch point areas and were required to document this. This was then audited on a monthly basis. The audit results showed that there was good completion of this on Headley, Highclere and Theale wards, but that there were gaps identified on Kingsclere, Bucklebury and Hermitage wards.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, the clinic rooms on Kingsclere and Headley wards were very small and the clinic room on Bucklebury was dirty, with cobwebs on the cupboards. We also observed that staff on Hermitage and Bucklebury wards were slow to find the relevant key to open things such as the drugs fridge or a cupboard where fire extinguishers were stored. This was because they had a large bundle of keys.

Staff usually checked, maintained, and cleaned equipment. However, we found some gaps in the daily checks of fridge and room temperatures on Kingsclere ward.

Safe staffing

The service had enough nursing staff to keep patients safe. The service had enough medical staff. Staff received basic training to keep people safe from avoidable harm.

Requires Improvement

Forensic inpatient or secure wards

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had a nursing vacancy rate of 20%. They had high use of bank and agency nurses and healthcare assistants to help cover shifts. Between 1 June 2021 and 31 August 2021 bank and agency staff completed 53.5% of shifts on Theale ward, 49.6% of shifts on Bucklebury ward, 36.7% shifts on Highclere ward, 23.1% of shifts on Hermitage ward, 22.2% of shifts on Kingsclere ward and 20.6% of shifts on Headley ward. Where possible, managers requested staff familiar with the service. The senior leadership team had plans in place to try and recruit more staff for the hospital and there was a central recruitment team dedicated to this. They also recruited international nurses, advertised on the provider's website and external recruitment boards, held open days, put out radio adverts and dropped flyers in the local area.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had relatively low staff turnover rates, the average from 1 June 2021 to 31 August 2021 was 7.9%.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients. For example, we observed that where patients required one to one observation extra staff had been requested.

The service had enough staff on each shift to carry out any physical interventions safely. Each ward had a designated responder to assist with incidents on other wards when required.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was always a doctor available within the hospital as well as a consultant and a junior doctor on call.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff were able to complete e-learning training at home within their own time and received renumeration for this.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was one of the items reported on within clinical governance meetings.

Requires Improvement

Forensic inpatient or secure wards

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Nurses also completed risk assessments prior to patients going out on section 17 leave.

Staff used a recognised risk assessment tool. Staff utilised the Short-term Assessment of Risk and Treatability (START) and Historical Clinical and Risk Management (HCR-20) assessment tools.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. However, we found that staff on Bucklebury ward did not always include mitigation plans for identified risks within patient's care records.

Staff identified and responded to any changes in risks to, or posed by, patients. However, patients on Hermitage and Bucklebury wards told us that they did not always feel safe on the wards due to the risk of violence and aggression from other patients. Between 1 June 2021 and 31 August 2021 there had been 86 incidents of violence and aggression on Bucklebury ward and 13 incidents of violence and aggression on Hermitage ward. The vast majority of these incidents resulted in either low or no harm being sustained. We saw evidence that where incidents had occurred, staff had responded appropriately and supported patients to report any incidents involving aggression to the police.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were advised that their belongings would be searched on admission and a list made of their possessions. Staff also used a metal detector when patients were admitted and when they returned from leave. This helped to ensure that no high risk items were brought onto the wards.

Use of restrictive interventions

Levels of restrictive interventions were low. Between 1 June and 31 August 2021 there had been 29 incidents where restraint was used across Bucklebury, Hermitage and Theale wards. One of these incidents involved prone restraint. There were no restraints on Kingsclere, Highclere or Headley wards.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The restrictive intervention training given to staff was certified as meeting the restraint reduction network standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients had preventing violence and managing aggression plans which staff utilised to help manage incidents.

Staff followed NICE guidance when using rapid tranquilisation, although this was rarely used. Between 1 June and 30 August 2021 there had been two uses of rapid tranquilisation on Theale ward and two uses on Bucklebury ward. None had been used on the other wards.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

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.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff on most wards kept up to date with their safeguarding training. However, only 72% of staff on Bucklebury and 73% of staff on Hermitage wards were up to date with this. Eleven senior staff from a variety of disciplines had also completed level four safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff we spoke with had good knowledge of safeguarding procedures and were able to give examples of action they had taken to safeguard patients when needed. The hospital held a quarterly safeguarding panel which was attended by representatives from the local authority, Provider Collaborative and CQC.

Staff followed clear procedures to keep children visiting the hospital safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with knew how to make a safeguarding referral and who their designated safeguarding officer was. The deputy hospital director held the safeguarding lead role while recruitment for a lead social worker was taking place.

Staff access to essential information

Staff had easy access to clinical information.

Staff could easily access patients' notes.

When patients transferred to a new team, there were no delays in staff accessing their records. All wards utilised the same electronic system which meant that when patients were transferred staff on the new ward were able to access the patient's care records instantly.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. Some processes for administering medicines could be unclear. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes when prescribing, recording and storing medicines. However, we found that systems and processes could have been improved to make the administration process clearer for nursing staff. The

provider did not have a policy around protocols for pro re nata (as required) medication. This meant that multiple medications could be prescribed for the same patient for the same reason, e.g. agitation, and it was not clear for staff which one to administer in the first instance. Following the inspection the hospital director raised this with the provider's group director of nursing and group medical director so that the policy could be reviewed. On Headley ward we also found that one patient had two different T2 forms completed by two different doctors and authorising different medications. A T2 form confirms that a patient is capable of understanding the nature, purpose and likely effects of a treatment and that they have consented to receiving this. Staff administering medications are required to check that the appropriate treatment authorisation is in place prior to doing so. T2 forms can only be completed by the clinician in charge of the patient's care. Therefore, having two different forms signed by two different doctors authorising different medications could lead to staff not administering a medication that should be given, for example if they thought the more recent form signed by a different doctor was the valid one.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff gave patients information and advice when medicines were prescribed and during ward rounds. Patients on some wards were able to self-administer medicines and there was a process in place to support patients through the different stages of this. Where patients were self-administering medicines they had a locked cupboard in their bedroom to store them in.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed safety alerts within clinical governance meetings.

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

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

The service reported four serious incidents between January and August 2021. Three of these were expected deaths and one was a patient who absconded whilst on section 17 leave.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team but not the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Between 1 June and 31 August 2021 staff reported 431 incidents on the forensic wards. The most common incident type was violence and aggression.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Staff reported serious incidents clearly and in line with the provider's policy.

Requires Improvement

Forensic inpatient or secure wards

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed staff after any serious incident. However, some staff told us they would appreciate more support following incidents, for example for managers to make an effort to ask how they were in the days/weeks following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The Provider Collaborative's serious incident panel also reviewed any serious incident reports. A Provider Collaborative is a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population.

Staff received feedback from investigation of incidents on their wards but not from other wards. Staff we spoke with said they would hear about incidents on other wards and any lessons learned if they covered a shift on another ward, but that these were not routinely disseminated across the hospital. Managers told us that lessons learned from incidents across the hospital would be shared in the morning business meetings, however this information was not then passed on to staff on the wards.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. On Theale ward there had been an increase in incidents of racial abuse, so staff had arranged for local police to visit the ward and speak to patients.

Are Forensic inpatient or secure wards effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and on most wards were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff checked patient's physical health observations at least weekly using the National Early Warning System (NEWS2), or more frequently if indicated. When we reviewed NEWS2 charts it did not always state whether scores had been escalated when they reached the threshold for this. We raised this with managers who were aware that details of escalations were not being recorded in the correct place, and that this had been highlighted via internal auditing processes as an area for improvement which would be reviewed via monthly clinical governance meetings.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

The quality of care plans was variable. Care plans on Kingsclere, Highclere, Theale, Headley and Hermitage wards were personalised, holistic and recovery-oriented. However, care plans on Bucklebury ward were less personalised and we found examples where they contained the wrong patient's name because the information had been copied and pasted from another patient's care plan.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The psychology team provided individual therapies for patients tailored to individual needs. These included therapies which were trauma focused, schema work and cognitive behavioural therapy.

Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. A GP visited the hospital twice a week. A dentist and a chiropodist also regularly visited the hospital. We saw evidence that patients were taken off site to attend appointments with various other specialists. There was also a full-time physical health nurse and a full-time associate physical health nurse for the hospital.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The hospital had recently recruited a dietician to work one day a week.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a no smoking policy and supported patients with nicotine replacement therapy or by offering vaping products. The hospital also had a weight management programme.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff utilised the health of the nation outcome scale (HoNOS).

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. Patients had access to psychology, occupational therapy, art therapy, drama therapy and speech and language therapy. Each ward had an occupational therapy assistant to deliver activities for patients. Occupational therapists carried out patient assessments but usually covered multiple wards, depending on the ward size.

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

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

Managers supported staff through regular, constructive appraisals of their work. All staff on Headley, Hermitage, Highclere and Kingsclere wards had received an appraisal in the last year. Eighty-seven percent of staff on Bucklebury ward and 81% of staff on Theale ward had also received an appraisal.

Managers supported staff through regular, constructive clinical supervision of their work. Managers also supported staff with reflective practice sessions which were either run by a psychologist or an art therapist. Although there was no lead social worker in post, managers ensured that the social work team continued to receive supervision from an external supervisor from another hospital run by the provider. Junior doctors were supervised by consultants, consultants were supervised by the medical director and there was also a peer support group for consultants.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. The hospital had recently invested in training in dialectical behavioural therapy for staff.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. However, some multidisciplinary team staff who did not attend handover told us they did not always receive important information.

Ward teams had effective working relationships with other teams in the organisation. The director of nursing ran a daily site meeting which was attended by all ward managers for them to give an update on things such as staffing, observation levels and incidents. This helped ensure that managers were aware of what was going on across the hospital. We saw evidence of where staff supported other teams within the hospital. For example, where the psychology team had delivered training and offered extra reflective practice sessions to support staff to care for a patient with challenging behaviour on Headley ward.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff could not always ensure that patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was due to staffing issues at the hospital.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings in clinical governance meetings. However, on Bucklebury ward we found that a patient had been prescribed medication without the appropriate treatment authorisation in place. This had not been picked up by internal auditing processes.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Requires Improvement

Forensic inpatient or secure wards

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Are Forensic inpatient or secure wards caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Patients told us that staff always knock on their bedroom door before entering. We observed staff speaking about patients in a respectful manner throughout our inspection.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient. Staff knew patients well and we saw lots of examples of person-centred care being delivered.

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

Staff followed policy to keep patient information confidential.

Requires Improvement

Forensic inpatient or secure wards

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each ward had a peer support representative who helped to show new patients around and explained the ward systems and procedures to them. Staff also gave patients an information booklet which contained key information about the hospital.

Staff involved patients and gave them access to their care plans and risk assessments. Patients told us that they reviewed their care plans with staff once a month and that staff always asked them what they would like to be included.

Staff made sure patients understood their care and treatment. Patients we spoke with all felt supported to understand their care and treatment. They had been involved in setting goals and were aware of steps they needed to take to progress towards being discharged.

Staff involved patients in decisions about the service, when appropriate. The hospital had a patient council which was made up of patient representatives from each ward and was attended by the senior leadership team. They were consulted about changes to the service, for example, changes to the newly refurbished dining room or updating the patient information booklet. Patient representatives also attended both ward and hospital based clinical governance meetings. Staff ran fortnightly community meetings on the wards which were chaired by patients and provided opportunities for them to give feedback about their care. Any issues which could not be resolved within the community meetings were escalated to the patient council.

Patients could give feedback on the service and their treatment and staff supported them to do this. All of the wards had a “you said, we did” board which showed suggestions patients had made and actions taken by staff.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Staff displayed posters detailing how to access advocacy services in all ward areas. Patients told us that they access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Relatives we spoke with gave positive feedback about the hospital. They told us that they felt involved in the care of their loved ones. Staff had begun utilising online video services to conduct CPA meetings during the pandemic which meant that more relatives were able to dial in, particularly those who lived some distance away.

Staff helped families to give feedback on the service. Staff had recently started running monthly online meetings for carers which hospital staff gave presentations at. The hospital had also recently run a carers survey.

Are Forensic inpatient or secure wards responsive?

Requires Improvement

Forensic inpatient or secure wards

Requires Improvement

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

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, patients rarely had their discharge delayed for other than clinical reasons.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Discharge and transfers of care

The service had low numbers of patients whose discharges were delayed and these were monitored by managers. There was only one patient who had their discharge delayed on Theale ward. Staff were working with the patient's case manager to try and source a suitable placement.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Communal areas of the ward were also tailored to the patient group. For example, on Highclere ward there were pictures of celebrities from the 1950s/60s on the walls.

Patients had a secure place to store personal possessions. Patients either had lockable storage in their bedrooms or access to a locker in the communal area of the ward which they had a key for.

The service had a full range of rooms and equipment to support treatment and care. All of the wards had well equipped group rooms. However, on Bucklebury there was a lack of communal space. The ward was also very noisy. The hospital also had a gym which patients could use. The equipment in the gym was old, however staff told us that new equipment had been ordered and would arrive in October 2021.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients had access to mobile phones and there was also a payphone available on each ward.

All wards had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. Each ward had galley kitchen facilities for patients to make hot drinks. On some wards patients also had access to a full kitchen but this was dependent on individual risk assessment. We observed staff on Highclere ward offering to make drinks for patients who may have struggled to make their own.

The service offered a variety of good quality food. Patients had a choice of going to the communal dining room for lunch/dinner or remaining on the ward. The communal dining area had recently been refurbished and had a very pleasant atmosphere, including a large mural on the wall which patients had helped to create, and dimmable lighting. A patient survey carried out in September 2021 showed that 65% of respondents felt there was enough choice of food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. Patients were not always able to take their designated section 17 leave due to a lack of staff being available to facilitate this.

Managers could not always ensure that shifts were filled which meant that patients were not always able to take leave from the wards. Between 1 June 2021 and 30 August 2021 4.2% shifts on Hermitage ward, 3.8% shifts on Kingsclere ward, 3.7% shifts on Headley ward, 2.9% shifts on Highclere ward, 2.8% shifts on Theale ward and 2.2% shifts on Bucklebury ward had not been filled. When this happened, managers moved staff around from other wards to ensure the wards with the highest needs/risk were covered, however this still put pressure on staff on other wards to ensure that all relevant tasks were completed. Patients and staff told us that section 17 leave was often cancelled due to lack of staff.

The hospital offered some paid and voluntary work positions within the hospital, for example doing gardening, in the gym and running the patient café on a Saturday. All of these roles had clear job descriptions in place and patients were required to apply for them and attend an interview. Staff then provided them with a contract of employment. The occupational therapy team also ran a "groundbusters" team which took grounds jobs from the estates team for patients to complete. The hospital ran the Crookham common conservation project which involved patients maintaining the common and ensuring it was kept clean and tidy. Patients were involved in maintaining a lock at a local canal. Tutors from a nearby local college attended the hospital one day a week to deliver courses in numeracy and vocational skills. A healthcare assistant with a background in IT was also running an IT course for patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Requires Improvement

Forensic inpatient or secure wards

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Wards supported disabled patients and Highclere ward was dementia friendly.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. This information was displayed on notice boards on the wards.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room at the hospital. Priests and Imams also visited. Patients were supported to attend church on Sundays.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Where complaints were upheld, action plans were created to ensure improvements were made.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Forensic inpatient or secure wards well-led?

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The hospital director was a visible presence throughout the hospital. Patients told us that the hospital director frequently visited the wards and would engage in activities with them, for example playing pool. Staff told us that other members of the senior leadership team were less visible on the wards but that they were contactable if needed. The director of nursing was relatively new in post and still developing into her role, her team and the vision and direction for nursing.

The senior leadership team had a good understanding of the key challenges the service faced. They were focused on improving recruitment and retention to improve the service for both patients and staff. The provider had worked to develop career progression pathways for staff at all levels to try and improve retention. The hospital director was also working with the group Human Resources director on a project to improve staff recruitment and retention.

Leaders were supported to complete leadership training. For example, the hospital's director of nursing was completing level seven leadership training and some of the ward managers were completing level five. Completion of the training required staff to complete a project which was then used to improve practice at the hospital. For example, staff were completing projects around how to improve the induction for healthcare assistants and least restrictive practice.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The organisation's values were kindness, integrity, teamwork and excellence (KITE). Staff we spoke with were aware of these and how they impacted on their day to day working. Staff told us that their development objectives were linked to the organisation's values. Some of the occupational therapy team were working with patients to make a large kite to display the values.

Culture

Most staff felt respected, supported and valued. They said the organisation promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Leaders told us they were proud of how well the staff had supported the patients and one another through the challenges of the last couple of years.

Staff had mixed views on how well supported they were. Some staff felt well supported; others told us they felt over-worked and under-valued. Staff told us they would be comfortable to raise concerns if needed, either at ward manager level or with the senior leadership team.

The senior leadership team held staff forums twice a month which were held both during the day and at night to ensure all staff had the opportunity to attend. Actions from the meetings were documented and updates given at subsequent meetings. Where staff suggestions had not been implemented, a rationale had been documented.

The provider ran a staff recognition scheme called "star award". Staff could nominate one another to receive an award and then the operations director selected "stars of the month".

Governance

Our findings from the other key questions demonstrated that some governance processes required improvement.

Requires Improvement

Forensic inpatient or secure wards

The service had governance structures in place. Each ward had a monthly governance meeting and there was also a hospital governance meeting. There was a regional governance meeting which was attended by all hospital directors in the south of England and Wales, and there was a corporate governance meeting which covered all sites. Information from the corporate, regional and hospital governance meetings was cascaded to ward staff via their monthly governance meetings.

The hospital had a restrictive practice committee which was chaired by the ward manager from Donnington ward. They were working with the regional governance lead to develop an audit tool for restrictive practice which staff could complete with patients. However, the monthly committee meetings were not always well attended, for example in July 2021 only the meeting chair had attended. The provider had also recruited a regional violence reduction lead who would be working with teams to look at reducing restrictive practice.

The hospital director chaired a regional seclusion and long-term segregation review panel. Senior clinicians from across the region attended these meetings to identify any trends in where seclusion is occurring, times of day and duration of episodes. No trends had yet been identified in relation to the use of seclusion and long-term segregation at Thornford Park.

Our findings from some of the other key questions indicated that some governance processes required improvement. For example, we found that a patient on Headley ward had two T2 authorisation forms in place which could cause confusion for nursing staff. This had not been picked up via the provider's quality assurance processes. We also found there was variation in the quality of care records on the forensic wards. For example, the records on Kingsclere ward were holistic and comprehensive, whereas the records on Bucklebury ward had identified risks that did not have clear mitigation plans in place and the care plans on this ward were not as personalised as examples we saw on other wards, with some being clearly copied and pasted from one patient's records to another.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had good access to the resources required to carry out their work effectively.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

All managers had access to an online dashboard which showed data on a variety of topics for their wards such as when section rights were due to be renewed or when care plans were coming up for review. This enabled them to prompt staff about completing these things to ensure they were all done in time.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local Provider Collaborative.

Requires Improvement

Forensic inpatient or secure wards

The hospital worked closely with the Provider Collaborative. Members of the senior leadership team attended the Provider Collaborative's serious incident panels, reducing restrictive practice committee, learning disability and autism and clinical governance meetings. Leaders told us that these meetings were very useful for sharing lessons learned across the region.

Learning, continuous improvement and innovation

The service participated in the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services (QNFMHS).

Staff were in the process of implementing safe wards, with different wards trialling different initiatives, e.g. some wards had brief biographies about staff on their notice boards, others were using soft words.

Staff carried out simulations of emergency events to practice their response. Debriefs took place following these simulations and action plans were developed to address any areas for improvement. Managers kept oversight of action plans via monthly clinical governance meetings.

Good

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Good

We rated safe as good.

Safe and clean care environments

Both wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. The nominated safety/security staff member carried out environmental checks every day. All faults or damages were documented and reported to the appropriate department for repair or removal. The ward manager audited these each week and authorised sign off when completed.

Staff were able to observe patients at all times and any areas that were blocked or unclear were mitigated by staff observations, mirrors and cameras. We did identify that the galley kitchen was an area out of sight to staff, as well as the telephone room and parts of the lounge, but were assured that these would be observed by staff out on the ward.

There was no mixed accommodation on the ward.

The identified ligature points had all been removed and anti-ligature doors were used throughout the ward. Staff were aware of where to locate the ligature cutters which were stored safely in the staff office. All staff were aware of the alarm system, carried a personal alarm and radio and there were alarm buttons in each of the patient bedrooms and bathrooms. There was a visible digital notification board identifying incidents and location. Staff on Tadley ward were unable to locate the ligature audit for the ward.

Maintenance, cleanliness and infection control

The ward areas were very clean and the housekeeper was observed to be maintaining a high standard of infection control throughout the day with regular surface and door cleaning.

We saw copies of cleaning records for the day and week had been completed and signed off by a manager.

Staff acted in accordance with the policy for infection control, handwashing and use of hand gels.

All staff were wearing masks at all times.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked and recorded daily/weekly in line with service policies.

Clinic rooms were clean and organised. There was an accessible treatment room in the main building area which housed the treatment bed, this was used by visiting GPs to treat patients.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Usual staffing for the wards was two Registered Nurses during the day and two at night. There were five healthcare assistants during the day and three at night.

Ninety-one percent of all shifts that went to agency/bank were filled.

Seven shifts were not fully staffed in August. In these instances managers utilised staff from other wards across the hospital.

All staff were given an induction to the ward. Bank staff completed the provider's internal induction and training. Regular agency staff completed ward specific training. Agency staff on the preferred use list had the same training as ward staff.

The ward had enough staff to ensure risk management and patient safety.

All patients had one to one time and this was agreed and reviewed weekly in the named nurse's supervision and logged on the computer system. All activity was recorded on the system so managers could see the meaningful activity completed by each patient.

Staff were supported by the managers when they required time away due to illness, but if there were more than three episodes of sickness in a 12 month period the staff member was not paid, pending review and Occupational Health assessment.

Levels of sickness were low and reducing.

The managers could increase staffing numbers on the ward as and when observation levels were increased. At the time of the inspection there were six healthcare assistants during the day and four at night due to patients requiring one to one observation.

Medical staff

A GP visited the hospital two days a week and the ward psychiatrist was available during the day 09.00 to 17.00 and an on-call system was available 17.00 to 09.00 covered by the junior doctors.

All locum doctors had a local induction prior to working in the hospital. They were able to get to the ward within 30 minutes of a call.

Mandatory training

Staff completed and kept up to date with their mandatory training.Staff were able to complete e-learning training at home within their own time and received remuneration for this.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was one of the items reported on within clinical governance meetings.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Nurses also completed risk assessments prior to patients going out on section 17 leave.

Staff used recognised risk assessment tools. Staff utilised the Short-term Assessment of Risk and Treatability (START) and Historical Clinical and Risk Management (HCR-20) assessment tools.

Staff had developed some very thorough and detailed risk assessments. These were easy to understand and follow and staff we spoke to were fully aware of them and how to implement them.

Staff followed procedures to minimise risks where they could not easily observe patients. We were able to see the observation levels of patients being implemented and recorded.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Patients we spoke to said they felt safe on the wards and that the staff kept them safe and made them feel safe.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff used verbal de-escalation as a preference and on Donnington ward re-directing patients to an area where they could undergo a one to one session to problem solve was always the preferred option. On Donnington ward there had been two physical interventions since April 2021 for two different patients.

Seclusion was used on Tadley ward and there had been two seclusions in the last 12 months. The seclusion area complied with the requirements of the Mental Health Act Code of Practice and had access to fresh air. Seclusion was only used as a last resort on Tadley ward and the preferred and most effective intervention was verbal de-escalation.

Safeguarding

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.

All staff had received safeguarding training, managers notified them when refreshers or updates in training were required.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff we spoke with had good knowledge of safeguarding procedures and were able to give examples of action they had taken to safeguard patients when needed. The hospital held a quarterly safeguarding panel which was attended by representatives from the local authority, Provider Collaborative and CQC.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Children were not allowed on the ward but there was a family room available for visits.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff made safeguarding referrals when patients were cared for in long term seclusion.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Staff could easily access patients' notes.

When patients transferred to a new team, there were no delays in staff accessing their records. All wards utilised the same electronic system which meant that when patients were transferred staff on the new ward were able to access the patient's care records instantly.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes when prescribing, support from an external pharmacy was efficient and monitored when medications required ordering and reviewing.

We reviewed 17 medicines charts and found there were three missed signatures on one chart, all other charts were complete and accurate. We raised this with staff and they agreed to look into the reason for this and acknowledged this should not be happening.

Our review of Olanzapine monitoring showed that although physical observations were adhered to, side effect monitoring was not complete.

We found that systems and processes could have been improved to make the administration process clearer for nursing staff. The provider did not have a policy around protocols for pro re nata (as required) medication. This meant that multiple medications could be prescribed for the same patient for the same reason, e.g. agitation, and it was not clear for staff which one to administer in the first instance. Following the inspection the hospital director raised this with the provider's group director of nursing and group medical director so that the policy could be reviewed. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

High fridge temperatures had been recorded on Tadley ward, however no action had been taken to address this.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed safety alerts within clinical governance meetings.

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

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff were aware of what incidents were, how to report and document them.

The service had no never events on any wards.

Staff were aware of the duty of candour and how to inform individuals and families when this was required.

Good

Wards for people with learning disabilities or autism

Managers were present following incidents and de-briefing was offered and documented. Staff on Tadley ward told us that support from managers following incidents could be improved, particularly in the days/weeks following an incident.

Managers investigated all incidents thoroughly and gave feedback to staff on their wards, however this was not shared with other wards.

Staff met to discuss the feedback and look at improvements to patient care.

Staff commented that they were very well supported following incidents and that they were listened to.

Are Wards for people with learning disabilities or autism effective?

Good

We rated effective as good.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

A comprehensive assessment was completed for each patient on admission, it was needs led, holistic and included activities of daily living.

Physical health assessments were completed either on or very shortly after admission.

The care plans were informative, achievable, needs led and well documented. They were also in easy read formats where appropriate and used in a scheduled manner on the autism ward. They were regularly updated, addressed current issues and had a plan for future discharge.

Each patient had a positive behaviour support (PBS) plan which was supported by a comprehensive assessment.

Physical care was documented and recorded weekly using the National Early Warning System (NEWS2), should observations be required more frequently, this was well documented and implemented.

The quality of the care plans throughout the service was of a high standard. They were reviewed at multi-disciplinary team (MDT) meetings and changes were made when issues were resolved or if further requests were made by the patient.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a wide range of care and treatment to meet individual needs.

Care was delivered within the best practice guidelines.

Staff had a good understanding of the PBS plans and worked jointly with MDT members to promote good outcomes with the individual patients.

Staff identified physical health needs, care planned them and documented this in patients' notes. Areas of need, for example, dietary needs were identified and patients were referred to a dietician for advice and support.

A GP visited the hospital twice a week.

A dentist and a chiropodist also regularly visited the hospital. We saw evidence that patients were taken off site to attend appointments with various other specialists. There was also a full-time physical health nurse and a full time associate physical health nurse for the hospital.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a no smoking policy and supported patients with nicotine replacement therapy or by offering vaping products. The hospital also had a weight management programme.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff utilised the health of the nation outcome scale (HoNOS).

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. Patients had access to psychology, occupational therapy, art therapy, drama therapy and speech and language therapy. Donnington ward also had a full time PBS practitioner.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. This included learning disability, autism and positive behaviour support training.

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

Managers supported staff through regular, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these with performance management.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were attended by the patients for ten minute slots to discuss their care or concerns.

We attended a full staff meeting on Donnington ward which was very well organised and presented staff with information and opportunities to contribute.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. The teams on both wards were proud to highlight their contact with external agencies in respect of patients moving on and updates. They also said that there had been an increase in attendance at care programme approach (CPA) meetings since these had been available to join online.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time. This was completed monthly and there were no omissions noted.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We observed this being discussed in the staff meeting, to ensure a good understanding and knowledge.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interests of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed to the Mental Capacity Act and acted when they felt this was necessary.

Good

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism caring?

Good

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition. There was a variety of communication schedules, door boards and general information posters displayed throughout the ward.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

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

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. There was a ward information pack available for patients and this was devised by two of the patients on the patient council.

Staff involved patients and gave them access to their care plans and risk assessments. These were available in an easy read document, pictorial and adapted documents to meet the individual needs of the patients. This was an assurance for all concerned that the plans were understood and agreed to. This applied to current and future plans.

Staff involved patients in decisions about the service, when appropriate.

Good

Wards for people with learning disabilities or autism

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. There were good, clear posters and details available on both wards, and by the telephone on each ward.

Staff involved patients in decisions about the service, when appropriate. The hospital had a patient council which was made up of patient representatives from each ward and was attended by the senior leadership team. They were consulted about changes to the service, for example, changes to the newly refurbished dining room or updating the patient information booklet. Patient representatives also attended both ward and hospital based clinical governance meetings. Staff ran fortnightly community meetings on the wards which were chaired by patients and provided opportunities for them to give feedback about their care. Any issues which could not be resolved within the community meetings were escalated to the patient council.

Patients could give feedback on the service and their treatment and staff supported them to do this. Both of the wards had a “you said, we did” board which showed suggestions patients had made and actions taken by staff.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Relatives we spoke with gave positive feedback about the hospital. They told us that they felt involved in the care of their loved ones. Staff had begun utilising online video services to conduct CPA meetings during the pandemic which meant that more relatives were able to dial in, particularly those who lived some distance away.

Staff helped families to give feedback on the service. Staff had recently started running monthly online meetings for carers which hospital staff gave presentations at. The hospital had also recently run a carers survey. One relative we spoke to said they had not been offered a feedback opportunity on Tadley ward.

Are Wards for people with learning disabilities or autism responsive?

Good

We rated responsive as good.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients rarely had their discharge delayed for other than clinical reasons.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

When patients went on leave there was always a bed available when they returned.

Managers and staff worked together to make sure patients were not moved before they were assessed as ready to move and the appropriate accommodation had been found.

Patients were not moved between wards.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

One patient had their discharge delayed in the last year.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. There appeared to be good working relationships with the MDT and outside agencies.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own room with en-suite facilities. The rooms we looked at were personalised and private, with some of the rooms having communication boards on the outside of the doors to inform staff of how the patients were feeling that day. The ward manager stated this had helped to reduce the levels of anxiety and reduce potential incidents if someone wished to be left alone until they felt better. The general décor was clean and fresh on both wards.

There were rooms on the ward for activities and quiet areas where people could go to a calm environment and have quiet uninterrupted discussions with staff. On Tadley the ward manager highlighted that they had converted what was his office, into a quiet room where much of the verbal de-escalation was undertaken, he said it had become a valuable asset to all.

Due to current circumstances visitors were not being accepted onto the ward, but there was an alternative provision at the reception area.

Patients could make phone calls in private. Patients had access to mobile phones and there was also a payphone available on each ward.

Patients could make their own hot drinks and snacks and were not dependent on staff. Each ward had galley kitchen facilities for patients to make hot drinks. On some wards patients also had access to a full kitchen but this was dependent on individual risk assessment. We observed patients making their own drinks on both wards.

There was a kitchen available for patient use providing they had undertaken an occupational therapy assessment and were deemed low risk to themselves and others, to use the equipment in the kitchen. These sessions are all supervised and planned.

Staff used a full range of rooms and equipment to support treatment and care.

The service had an outside space that patients could access easily. This was the case on both wards.

Some patients were more than satisfied with the quality and variety of meals available, but there were others who said the food needed to improve. The general opinion was that the new chef had made a big improvement.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work. The hospital offered some paid and voluntary work positions within the hospital, for example doing gardening, in the gym and running the patient café on a Saturday. All of these roles had clear job descriptions in place and patients were required to apply for them and attend an interview. Staff then provided them with a contract of employment. The occupational therapy team also ran a "groundbusters" team which took grounds jobs from the estates team for patients to complete. The hospital ran the Crookham common conservation project which involved patients maintaining the common and ensuring it was kept clean and tidy. Patients were involved in maintaining a lock at a local canal. Tutors from a nearby local college attended the hospital one day a week to deliver courses in numeracy and vocational skills. A healthcare assistant with a background in IT was also running an IT course for patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with communication needs or other specific needs. The variety of communication aides were excellent and needs led.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This information was displayed on notice boards on the wards.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room at the hospital. Priests and Imams also visited. Patients were supported to attend church on Sundays.

Good

Wards for people with learning disabilities or autism

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Wards for people with learning disabilities or autism well-led?

Good

We rated well-led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The hospital director was a visible presence throughout the hospital. Patients told us that the hospital director frequently visited the wards and would engage in activities with them, for example playing pool. Staff told us that other members of the senior leadership team were less visible on the wards but that they were contactable if needed. The patients we spoke to all said that the hospital director would speak to them and understood them. The director of nursing was relatively new in post and still developing into her role, her team and the vision and direction for nursing.

The senior leadership team had a good understanding of the key challenges the service faced. They were focused on improving recruitment and retention to improve the service for both patients and staff. The provider had worked to develop career progression pathways for staff at all levels to try and improve retention. The hospital director was also working with the group Human Resources director on a project to improve staff recruitment and retention.

Leaders were supported to complete leadership training. For example the head of nursing was completing level seven leadership training and some of the ward managers were completing level five. Completion of the training required staff to complete a project which was then used to improve practice at the hospital. For example, staff were completing projects around how to improve the induction for healthcare assistants and least restrictive practice.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The organisation's values were kindness, integrity, teamwork and excellence (KITE). Staff we spoke with were aware of these and how they impacted on their day to day working. Staff told us that their development objectives were linked to the organisation's values. Some of the occupational therapy team were working with patients to make a large kite to display the values.

Culture

Most staff felt respected, supported and valued. They said the organisation promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Leaders told us they were proud of how well the staff had supported the patients and one another through the challenges of the last couple of years.

Staff had mixed views on how well supported they were. Some staff felt well supported; others told us they felt over-worked and under-valued. Staff told us they would be comfortable to raise concerns if needed, either at ward manager level or with the senior leadership team.

At ward level on both wards there was a definite feeling of confidence to raise any issues with management without discrimination.

The senior leadership team held staff forums twice a month which were held both during the day and at night to ensure all staff had the opportunity to attend. Actions from the meetings were documented and updates given at subsequent meetings. Where staff suggestions had not been implemented, a rationale had been documented.

The provider ran a staff recognition scheme called "star award". Staff could nominate one another to receive an award and then the operations director selected "stars of the month".

Governance

Our findings from other key questions showed that most governance processes operated effectively at ward level.

The service had governance structures in place. Each ward had a monthly governance meeting and there was also a hospital governance meeting. There was a regional governance meeting which was attended by all hospital directors in the south of England and Wales, and there was a corporate governance meeting which covered all sites. Information from the corporate, regional and hospital governance meetings was cascaded to ward staff via their monthly governance meetings.

The hospital had a restrictive practice committee which was chaired by the ward manager from Donnington ward. They were working with the regional governance lead to develop an audit tool for restrictive practice which staff could complete with patients. However, the monthly committee meetings were not always well attended, for example in July only the meeting chair had attended. The provider had also recruited a regional violence reduction lead who would be working with teams to look at reducing restrictive practice. This remains an ongoing piece of work and something the manager on Donnington ward is enthusiastic and positive about.

The hospital director chaired a regional seclusion and long-term segregation review panel. Senior clinicians from across the region attended these meetings to identify any trends in where seclusion is occurring, times of day and duration of episodes. No trends had yet been identified in relation to the use of seclusion and long-term segregation at Thornford Park.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local Provider Collaborative.

The hospital worked closely with the Provider Collaborative. Members of the senior leadership team attended the Provider Collaborative's serious incident panels, reducing restrictive practice committee, learning disability and autism and clinical governance meetings. Leaders told us that these meetings were very useful for sharing lessons learned across the region.

Learning, continuous improvement and innovation

The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP) which involved patients on Donnington ward and was presented by therapists and ward staff.

Staff were in the process of implementing safe wards, with different wards trialling different initiatives, e.g. some wards had brief biographies about staff on their notice boards, others were using soft words.

Staff carried out simulations of emergency events to practice their response. Debriefs took place following these simulations and action plans were developed to address any areas for improvement. Managers kept oversight of action plans via monthly clinical governance meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that a range of therapeutic activities were available to meet patients' needs in the PICUs in accordance with guidance from the National Institute of Health and Care Excellence.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that there were sufficient staff to facilitate leave for patients on the forensic wards. The provider did not ensure that supervision was consistently managed on the PICUs.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that care records on the forensic and PICU wards were of a consistently good quality and that they included the patient voice. Some identified risks did not have clear mitigation plans in place. The provider did not ensure that there were robust systems in place to ensure it was clear for staff which medications had been authorised for patients on the forensic wards.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that it was consistently recorded what action has been taken when it was indicated that a NEWS2 score should be escalated on the forensic and PICU wards.

The provider did not ensure that emergency equipment audits were carried out on Curridge ward.

The provider did not ensure that the reducing restrictive practices policy was followed and understood by the staff teams on the PICU wards.

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Elysium Healthcare

Jo Sherman- Hospital Director/ Steve Conway- Operations Director

Elysium Operational Board

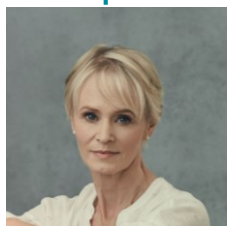
Joy Chamberlain
Chief Executive Officer

Keith Browner
Chief Financial Officer

Prof. Quazi Haque
Executive Medical Director

Kath Murphy
Director of Policy & Regulation

Michele Paley
Group Director of Nursing



Zsara Thomas
Commercial & Communications Director

Gareth Green
HR Director

John Rowland
Legal Director

Operations Directors

Registered facilities

Elysium's evolution

11 Hospitals

PRIORY

1st December 2016
2500 staff
802 service users
18 sites registered with CQC
3 sites registered with HIW
PiC Senior Management Team

10 Hospitals

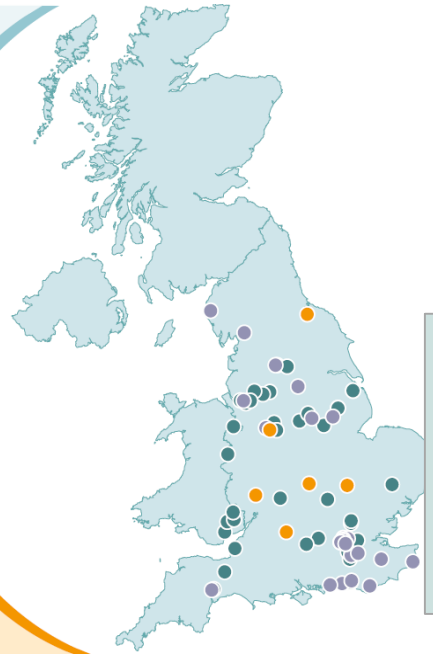
Partnerships in care
Changing lives for the better

Elysium Healthcare

Mental Health

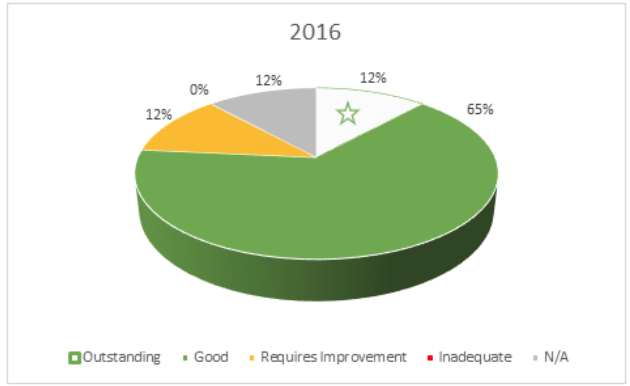
Complex Care

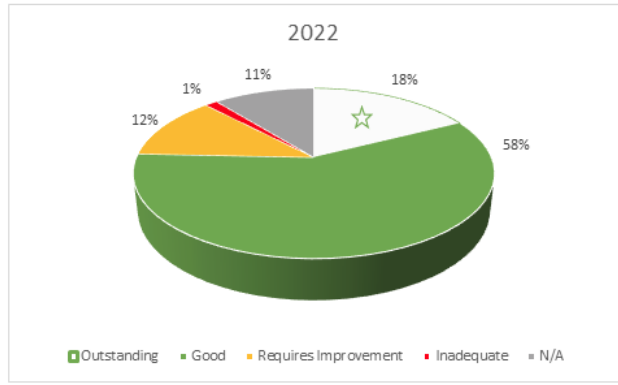
Neurological



April 2022

- **7200** staff
- **1801** service users
- **73** sites registered with CQC
- **5** sites registered with HIW
- **2** sites registered with CIW
- **255** Funders
- **23** Provider Collaboratives
- **233** CCGs, MHT, LA, etc.
- **1460** Hospital beds
- **604** Care home beds





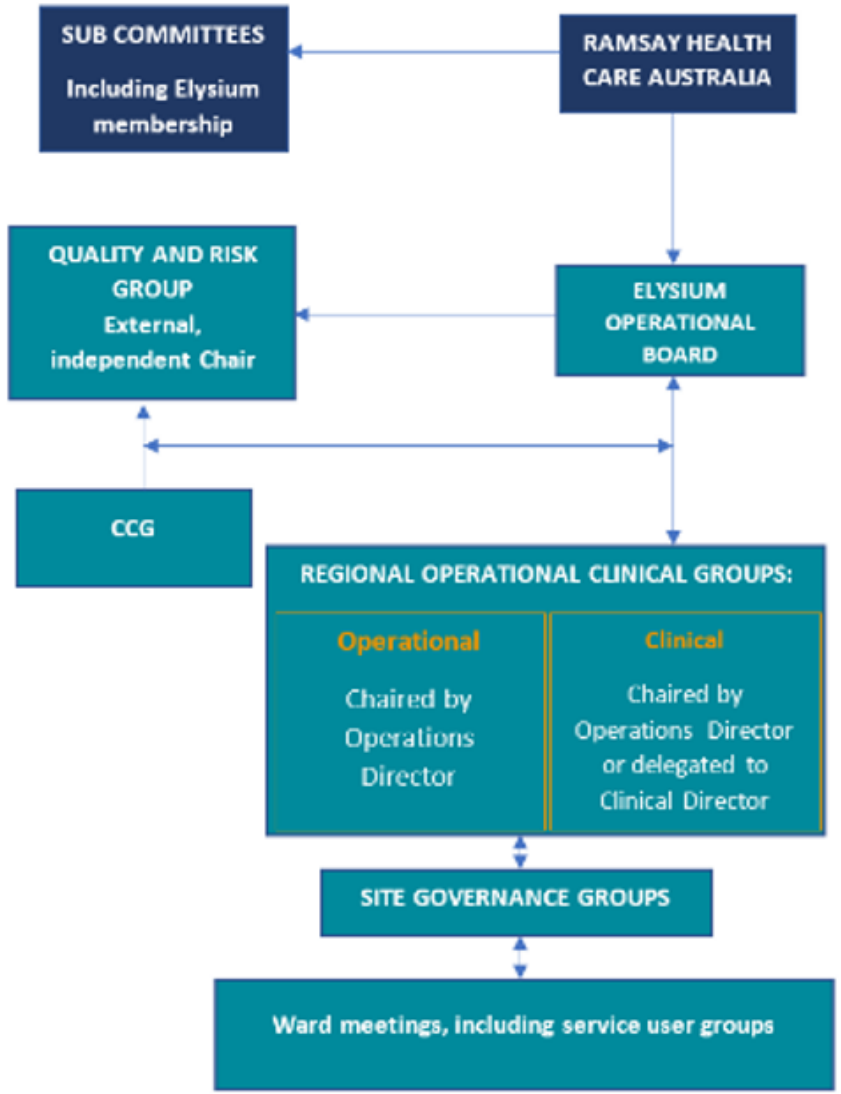
Our PURPOSE, Our PLAN, Our FUTURE 2022

Our strategic aims

- First choice provider
- Service users at the heart of what we do
- Championing service user rights
- Employer of choice
- Robust governance
- Improvement and learning via supportive culture
- Utilise technology for all
- Environmentally friendly
- Shared knowledge and expertise, shared growth
- To adapt and develop our services to meet need

To deliver on our strategic objectives we must deliver the **Best Care**, provided by the **Best People** in the **Best Place** which meet the needs of the population.

Our governance structure



Decisions made as close to the service user as possible

Registered Manager

Top priorities – Best Care

Supporting Our Service users

- Creation of Service User Advisory Group
- 2022 Service User Conference

Supporting the Transforming Care Agenda

- Continue to develop high quality local, community provision
- Review of out of area capacity

Safety

- New suite of Safety Initiatives launched

Quality Improvement Programme

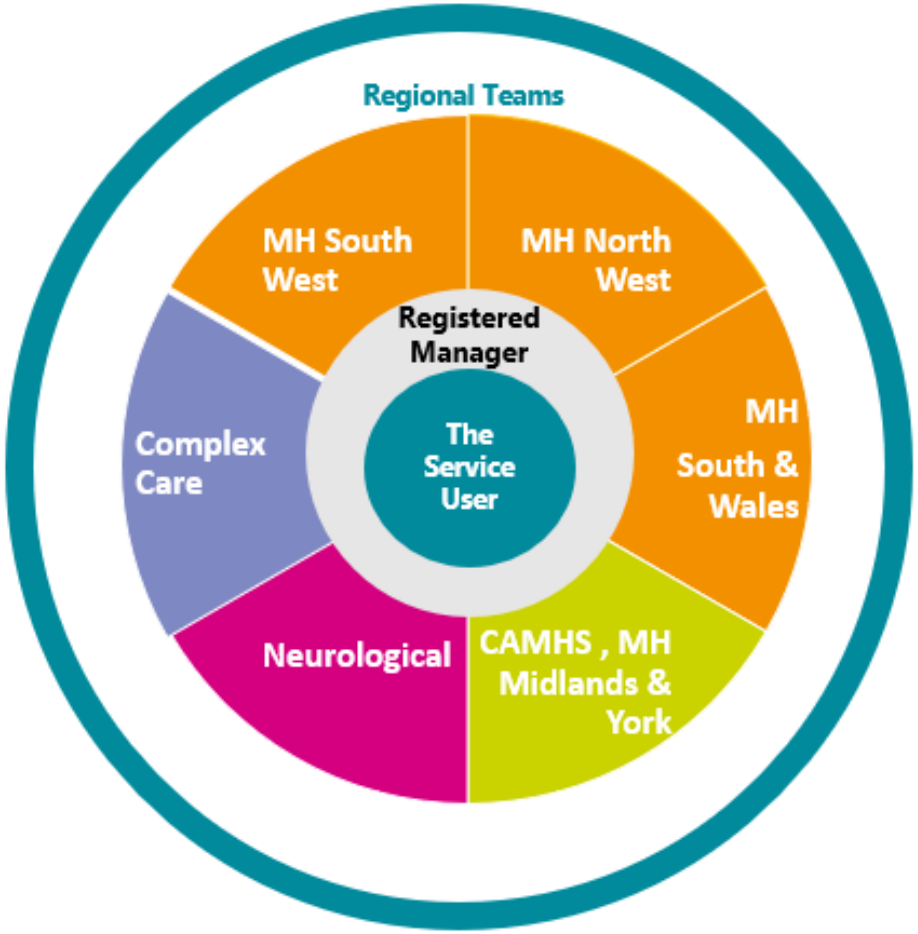
- Improvement Advisor Development Programme
- Good practice Hub
- Good Practice Bulletin
- Support of R&D

Assurance Systems

- Increased expertise for corporate oversight to support local delivery

Regional Structure

Steve Conway
Operations Director South



Thornford Park Hospital Structure - SMT

Jo Sherman
Hospital Director

Hazel Scott
Personal Assistant

David Pennells
Deputy Hospital Director

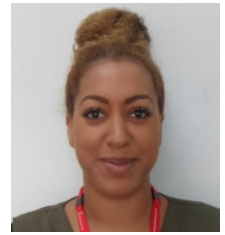
Dr Rao Nimmagadda
Medical Director

Samantha Lloyd
Director of Nursing

Anbu Batumalai
Director of Allied Health Professionals

Stephen Cassells
Director of Support Services

Bianca Weeks
HR Business Partner



Thornford Park Hospital

- 143 Registered Beds
- 11 Wards
- 3 MSU Male Wards (1x acute, 1x Rehabilitation and 1x LD)
- 1 Integrated Female MSU and LSU LD Ward
- 5 LSU Male Wards (1x Autism ward, 1x Older Persons ward, 1x Enhanced LSU)
- 1 PICU Male Ward
- 1 PICU Female Ward

Commissioning Pathway

- NHS England
- CCG

Thornford Park Hospital

CQC Action Plan

- *Regulation 9: The provider did not ensure that a range of therapeutic activities were available to meet patients' needs in the PICUs in accordance with guidance from the National Institute of Health and Care Excellence.*

- Director of Allied Health Professions reviewed the hospital therapeutic programme. Revised programme now in situ. Audits have been carried out and monitored within Clinical Governance

Thornford Park Hospital

CQC Action Plan Continued

Regulation 17: The provider did not ensure that care records on the forensic and PICU wards were of a consistently good quality and that they included the patient voice. Some identified risks did not have clear mitigation plans in place.
The provider did not ensure that there were robust systems in place to ensure it was clear for staff which medications had been authorised for patients on the forensic wards.
The provider did not ensure that it was consistently recorded what action has been taken when it was indicated that a NEWS2 score should be escalated on the forensic and PICU wards.
The provider did not ensure that emergency equipment audits were carried out on Curridge ward.
The provider did not ensure that the reducing restrictive practices policy was followed and understood by the staff teams on the PICU wards.

- Further coaching sessions delivered to MDT's regarding patient involvement within care planning
- Further NEWS2 coaching delivered to ward staff. Regular audits to monitor quality of documentation and reviewed within clinical governance
- Additional weekly audits of emergency equipment within Curridge ward, monitoring by Lead Nurse
- Quarterly audits to be undertaken by Lead Nurse regarding restrictive practice

Thornford Park Hospital

CQC Action Plan Continued

Regulation 18:
The provider did not ensure that there were sufficient staff to facilitate leave for patients on the forensic wards.
The provider did not ensure that supervision was consistently managed on the PICUs.

- Monthly auditing of cancelled leave through hospital clinical governance
- Monitoring of feedback through monthly patient forums
- Audit of supervision through hospital clinical governance

Thornford Park Hospital

External Audit / Governance of the Hospital

- NHS England
- Provider Collaborative
- NHS Wales
- CCG
- Local Authority
- Advocacy

Thornford Park Hospital

Areas of Achievement

- Promotion of least restrictive practice in enhancing access to leave

Thornford Park Hospital

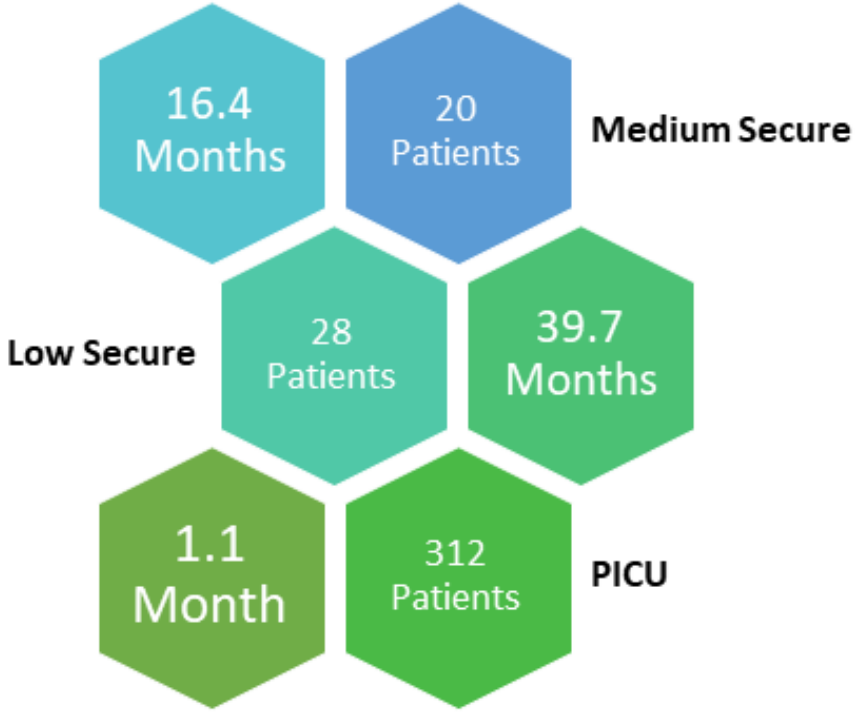
Areas of Achievement

- Collaborative working with External Stakeholders
- Development of Specialised Services that meet the needs of the health economy
- Management of COVID

Thornford Park Hospital

Areas of Achievement

- Promotion of least restrictive practices that enhance shorter length of stay



Royal Berkshire NHS Foundation Trust

Cancer Performance

Royal Berkshire NHS Foundation Trust

30th May 2022, v1.1

Agenda Item 6

what matters 2021

Cancer Services at RBFT

Royal Berkshire NHS Foundation Trust

Providing high quality, equitable, timely and personalised care utilising the latest evidence-based techniques and treatments

- 1 of 2 cancer centres in the Thames Valley Cancer Network
- Approx. 1600 new diagnoses of cancer per year (21/22)
- Serves a population of c. 750,000
- Close links with several tertiary centres for highly specialist surgery
- 4 main sites for cancer: Reading, Thatcham, Bracknell and Henley
- Radiotherapy delivered across 4 linear accelerators (2 Reading, 2 Bracknell)
- Chemotherapy delivered at Reading, Bracknell and Thatcham

Cancer Access Standards

Royal Berkshire NHS Foundation Trust

- 9 cancer access standards in 5 categories
  - 2 Week Wait: *14 days max. wait from referral to being first seen (test or appointment).*
  - 28 Days Faster Diagnosis Standard (FDS): *28 days max. wait from referral to diagnosis (cancer or otherwise).*
  - 31 Days First Definitive Treatment (FDT): *31 days max. wait from where the patient agrees to a treatment to treatment delivery.*
  - 31 Days Subsequent Treatment: *31 days max. wait from where the patient agrees and is clinically appropriate to treat (i.e. has recovered from previous treatment) until treatment starts.*
  - 62 Days Referral to Treatment (RTT): *62 days max. wait from referral to First Definitive Treatment.*
  - All standards have a tolerance to allow for individualised care – e.g. thinking time, highly complex tumours, social packages of care, other urgent life threatening treatment.
- National ambitions
  - Increase % of cancer found at the earlier stages (1 and 2) to 75% by 2028 (c. 55% currently)
  - Rapid diagnostic centres to assess and diagnose people.
  - Faster diagnosis standard (28 days above).
  - Personalised holistic care packages.
  - Cutting edge tests and treatments – e.g. genomic testing, proton beam treatment, immunotherapies.

Cancer Pathway

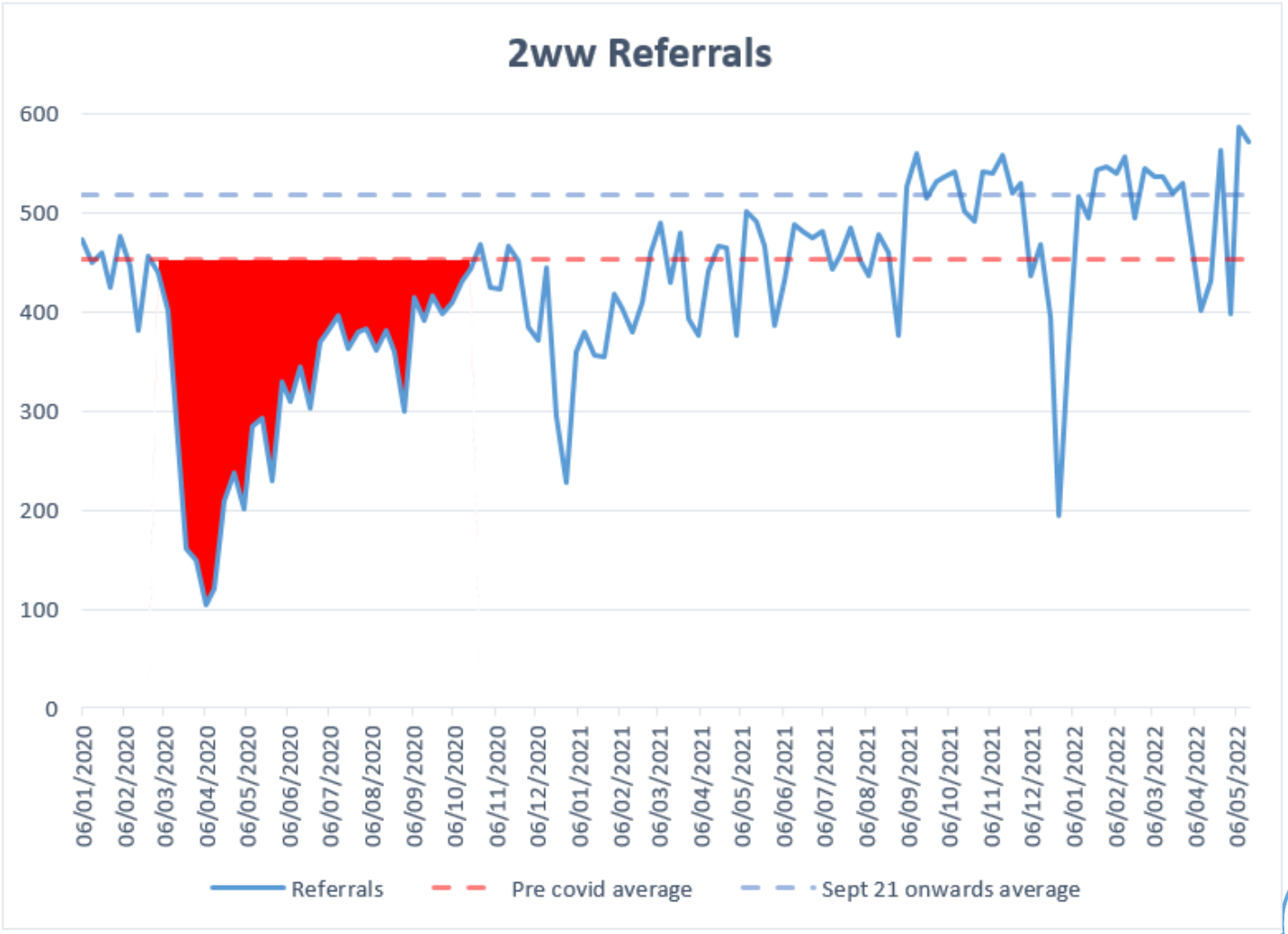
Royal Berkshire NHS Foundation Trust

CANCER RESEARCH UK

28 days from Referral to Diagnosis

2 week wait referrals

Royal Berkshire NHS Foundation Trust

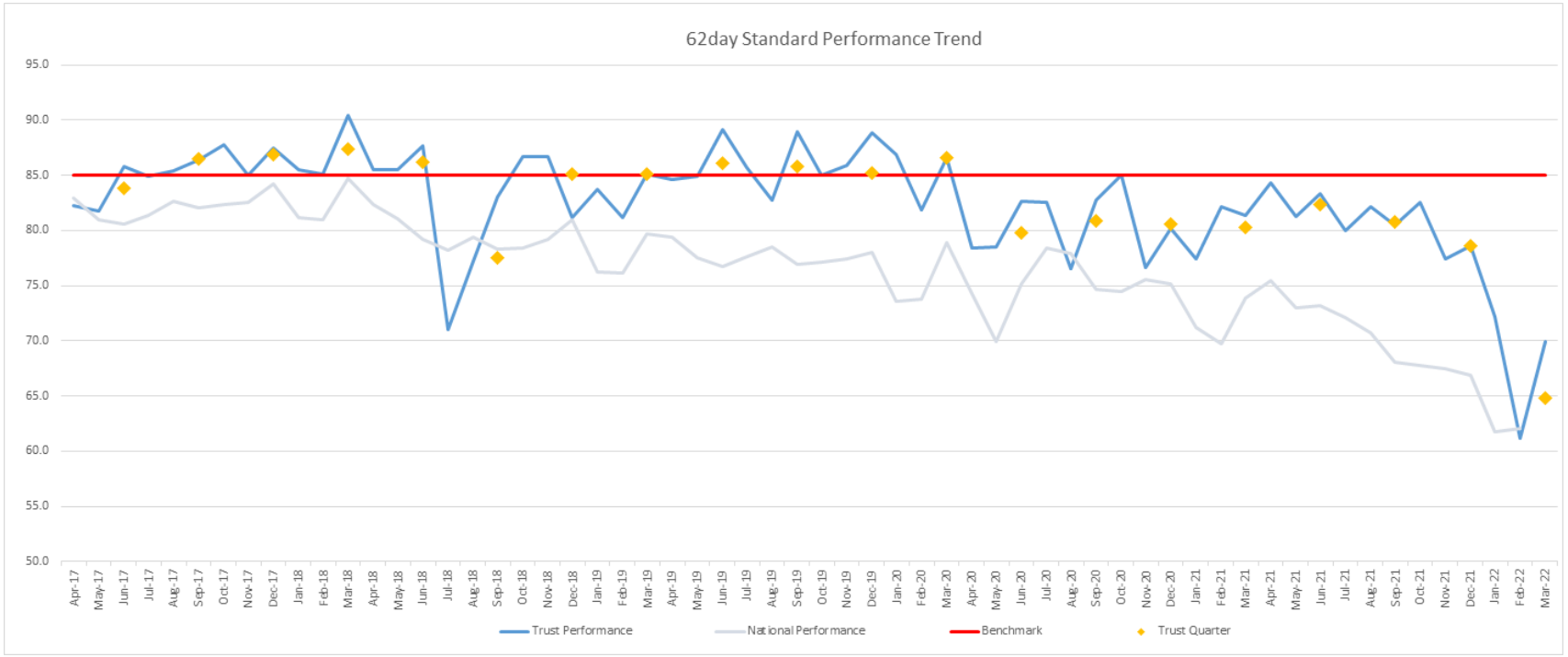


Compassionate | Aspirational | Resourceful | Excellent

what matters 2021

62 Day Cancer Access Standard

Royal Berkshire NHS Foundation Trust

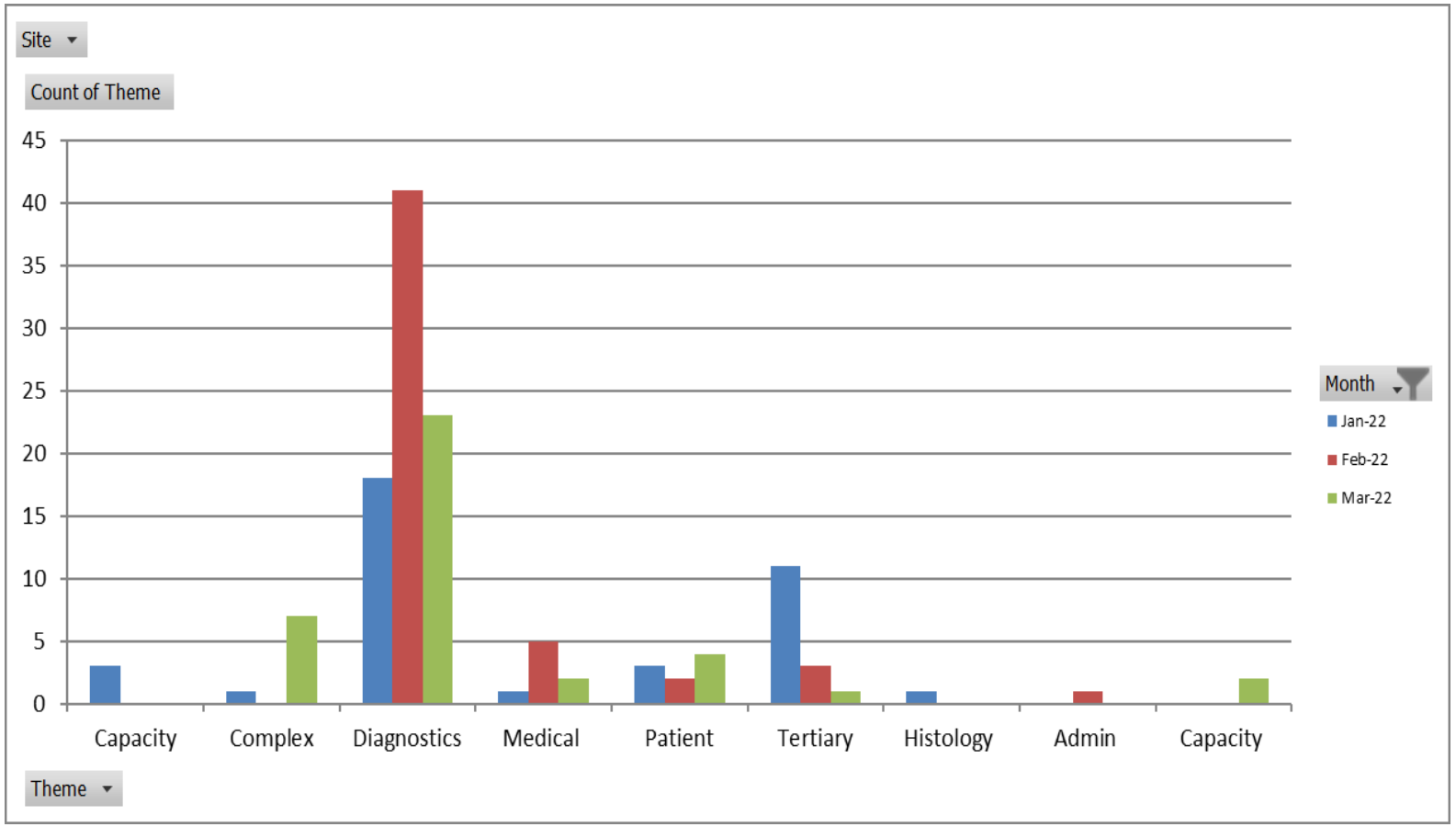


Compassionate | Aspirational | Resourceful | Excellent

what matters 2021

62 Day Breach Trend

Royal Berkshire NHS Foundation Trust

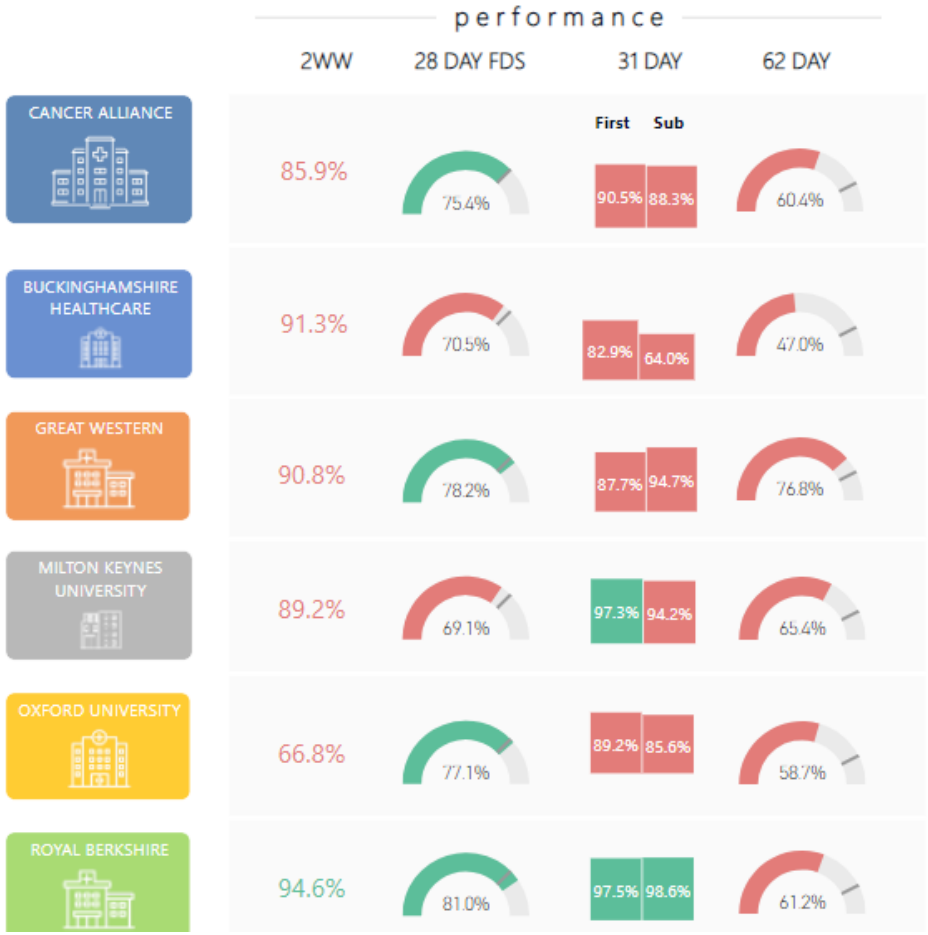


Compassionate | Aspirational | Resourceful | Excellent

what matters 2021

Thames Valley Position

Royal Berkshire NHS Foundation Trust



Compassionate | Aspirational | Resourceful | Excellent

what matters 2021

Actions taken

Royal Berkshire NHS Foundation Trust

- Executive led cancer steering group meeting each tumour site to inform the strategic response to sustained pressures.
- Recovery programmes for histopathology, diagnostics and elective care.
- Rapid diagnostic service in lung go-live early June.
  - Colorectal in progress. H&N and gynaecology to be scoped for phase 3.
- Mobile CT + MR. Static MR and PET due Dec 22.
- Workforce Innovation (CNS support workers, PAs, non-medic consultants, developmental roles, A&C navigators).
- Cancer rehabilitation virtual support sessions.
- EDI work addressing inequality with patients via cancer champions.
- Expanded psych and dietetics support, business case being developed for SALT.

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Wider Cancer Priorities – Berkshire West

Author: Peter Hunt (Cancer Programme Manager)
Presenter: Dr Kajal Patel (Cancer Clinical Lead)

19th May 2022, V1.0 FINAL

Achievements in 2021-22

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

All priorities taken from the local Cancer Framework and NHS Long Term Plan

- Recovery from COVID-19: working with system partners (e.g. Thames Valley Cancer Alliance, Cancer Patient Partnership Groups) to support with the recovery attributed to reduced cancer referrals and delayed cancer treatment

- Cancer Champions: raising cancer awareness in the most deprived / highest ethnic minority populations in Berkshire West. In addition, supporting cancer patients in these areas

- Cancer Collaborative Project: working with Polish, Urdu, Nepalese communities to develop leaflet for patients, in order to understand their cancer tests / results. Won recent national award

- Quality Improvement Scheme (QIS): increase patient screening uptake in primary care for Bowel, Breast and Cervical. Focus on LD and MH patients, as well as GP education

- Cancer Care Review Scheme: practices carry out health and wellbeing reviews for patients within 6 months (in parallel with QOF requirements)

Achievements in 2021-22

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Personalised Care: implementation of Breast Risk Stratified Pathway in Secondary Care. Holistic Needs Assessments (HNAs), End of Treatment Summaries and Health & Wellbeing Events (via our Cancer Rehab Service) offered to cancer patients

- Public Prostate Cancer Awareness Campaign: on the signs and symptoms of prostate cancer, to increase urgent cancer referrals

- GP Support & Education: webinars around FIT Symptomatic and local Vague Symptoms (SCAN) Pathway. Support Pack created for Cancer Earlier Diagnosis element of the PCN DES 21-22 and QOF QI Cancer ED Module 21-22

- BW ICP Cancer Steering Group: monthly meeting between key stakeholders (CCG, Trust, Macmillan, Thames Valley Cancer Alliance, Public Health) to discuss and agree on cancer priorities for our patients

Forward Planning 2022-2023

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Cancer Champions: successfully obtained funding for 22-23. Focus on health inequalities, by continuing to raise cancer awareness (cancer earlier diagnosis) & supporting cancer patients, in the most deprived / highest ethnic minority populations in Berkshire West

- Implement Faster Diagnosis (FD) Pathways in primary and secondary care: Lung and Colorectal

- Personalised Care Nurse Facilitators: support practices to improve the quality of Cancer Care Reviews offered to patients; and to ensure a seamless Personalised Care process for cancer patients between primary and secondary care. Includes understanding barriers in accessing CCRs for health inequality groups, and looking at ways in which to reduce any variation

- Personalised Care: implement Stratified Pathways in (for example) Colorectal and Prostate. Continue HNAs etc.

Forward Planning 2022-2023

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Public Cancer Awareness Campaigns: e.g. Skin in June 2022
- Continue GP Support & Education: webinars around Lower GI Pathway, mouth lesions, TVCA Dermatology training etc.
- Creation of PCN DES Cancer Earlier Diagnosis Support Pack 22-23: this includes focussing on health inequalities – e.g. increasing bowel / cervical screening in low uptake groups; increasing prostate cancer referrals in low uptake groups
- Continue to work with system partners to deliver cancer transformation and recovery from COVID-19: including Thames Valley Cancer Alliance (Workforce) and patient groups (e.g. BW Cancer Patient Partnership Group Projects)

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Health Scrutiny Committee – 14 June 2022

Item 7 – CCG Update

Verbal Item

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Health Scrutiny Committee – 14 June 2022

Item 8 – Healthwatch Update

Verbal Item

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West Berkshire Council Health Scrutiny Committee Protocol

Committee considering report:	Health Scrutiny Committee
Date of Committee:	14 June 2022
Portfolio Member:	Councillor Tom Marino
Report Author:	Gordon Oliver / Vicky Phoenix
Forward Plan Ref:	OSMC/HSC

1 Purpose of the Report

The report presents a final protocol that sets out how the West Berkshire Health Scrutiny Committee will work with bodies who commission or provide health and wellbeing services to residents of West Berkshire.

2 Recommendations

The Committee is recommended to:

1. Endorse the final protocol and the process for dealing with proposed substantial developments of variations to health services.

2. Recommend the protocol for approval by the Health Scrutiny Committee.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	There are no financial implications arising from this report.
Human Resource:	There are no HR implications arising from this report.
Legal:	The protocol sets out an approach to working with health partners, which is consistent with current legislation.
Risk Management:	There are no risks arising from the report. The protocol should actually reduce risks by providing clarity on what constitutes substantial variations or developments in delivery of health

	services and ensuring that proper scrutiny of such proposals takes place.			
Property:	There are no property implications associated with the report.			
Policy:	The report is consistent with national guidance on health scrutiny. The proposed protocol will help to achieve effective health scrutiny, which in turn will help to ensure that the priorities and objectives of the Berkshire West Joint Health and Wellbeing Strategy are delivered.			
	Positive	**Neutral**	**Negative**	**Commentary**
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?		✓		The protocol will help to ensure that the needs of all service users are taken into account when variations or developments in health services are proposed.
B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		✓		
Environmental Impact:		✓		There are no environmental impacts arising from this report.
Health Impact:	✓			The protocol will help to ensure effective health scrutiny of proposed variations and developments in health services that are considered likely to have substantial impacts for residents of West Berkshire.

ICT Impact:		✓		There are no ICT impacts arising from this report.
Digital Services Impact:		✓		There are no digital services impacts arising from this report.
Council Strategy Priorities:	✓			The protocol will help to ensure effective health scrutiny of proposed variations and developments in health services that are considered likely to have substantial impacts for residents of West Berkshire. This in turn will support the Council Strategy priority to 'support everyone to reach their full potential'. In particular, it will help with the following areas: - improve the health and wellbeing of our residents - improve mental health and wellbeing
Core Business:		✓		There are no core business impacts arising from this report.
Data Impact:		✓		There are no data impacts arising from this report.
Consultation and Engagement:	Health partners were consulted on the draft Health Scrutiny Protocol.			

4 Executive Summary

4.1 The consultation on the draft protocol has now taken place. No objections or suggested amendments were received and so it is proposed for the protocol to be approved.

4.2 Following the Health Scrutiny Committee on 5 April 2022 there have been some amendments to the protocol. This is to clarify the purpose of the protocol as set of working principals of West Berkshire Council and relevant health bodies rather than a signed agreement.

5 Supporting Information

Background

5.2 The draft protocol was approved for consultation at the Health Scrutiny Committee on 10 November 2021.

5.3 The draft protocol was sent to all relevant health bodies on 19 November 2021 with a request for responses by 7 January 2022.

5.4 The draft protocol was sent to West Berkshire Primary Care Networks, Berkshire Healthcare NHS Foundation Trust, NHS Berkshire West Clinical Commissioning Group (CCG), NHS England and NHS Improvement South East, Royal Berkshire NHS Foundation Trust and South Central Ambulance Service.

5.5 A joint response was received from Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust. They were supportive of the protocol with no amendments sought.

5.6 Responses were not received from the other health bodies by the 7 January 2022 deadline. We will re-engage with health bodies who we have not yet heard from after the establishment of the ICS on 1st July 2022.

Proposals

5.7 The protocol is included in Appendix A. The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards which set out how all parties will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and communities across West Berkshire.

5.8 It is proposed that the protocol be approved with no further amendments.

6 Other options considered

6.1 The requirement to develop a protocol is set out in the HSC Terms of Reference, so to 'do nothing' is not considered to be an option.

6.2 The Committee could re-consult with those health bodies that did not respond to the consultation. However this is not considered necessary, particularly in light of the fact that no proposed changes have been requested by those who have responded.

7 Conclusion

7.1 Creation of a Health Scrutiny Protocol would be a positive step in terms of improving communication between the HSC and local health bodies and having agreed actions and processes to be followed whenever a change in local health services is proposed.

8 Appendices

Appendix A – Draft Protocol between the West Berkshire Health Scrutiny Committee and commissioners and providers of health and wellbeing services to the population of West Berkshire.

Background Papers:

Health Scrutiny Committee papers from 10 November 2021

Subject to Call-In:

Yes: ☐ No: ☒

The item is due to be referred to Council for final approval	☐
Delays in implementation could have serious financial implications for the Council	☐
Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Overview and Scrutiny Management Committee or associated Task Groups within preceding six months	☒
Item is Urgent Key Decision	☐
Report is to note only	☐

Wards affected: All wards

Officer details:

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Document Control

Document Ref:		Date Created:	
Version:		Date Modified:	
Author:			
Owning Service			

Change History

Version	Date	Description	Change ID
1			
2			

West Berkshire Council Health Scrutiny Committee Protocol:

Working principles with commissioners and providers of health and wellbeing services to citizens of West Berkshire

(June 2022)

1 Introduction

1.1 This Protocol describes how the Council's Health Scrutiny Committee (HSC) will work together with the bodies that commission or provide health and wellbeing services for citizens of West Berkshire. This is not an agreement.

1.2 The Protocol defines some working principles to guide and support the relationship between the HSC and local health bodies.

1.3 It sets out the processes that will be followed when substantial variations or developments to health and wellbeing services are proposed that require formal consultation and engagement, as required by legislation. The Protocol also specifies how smaller variations and developments to health and wellbeing services will be handled.

2 Purpose of the protocol

2.1 The aim of this protocol is to provide:

- Improved engagement and communication across all parties;
- Clear standards about how we will work together;
- Greater confidence in the planning for service change, to secure improved outcomes for health services and citizens of West Berkshire.

3 Aims and responsibilities of health scrutiny

3.1 Guidance on health scrutiny, published by the Department of Health in June 2014, states that:

> *"the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe."*

3.2 West Berkshire Council has delegated responsibility for scrutiny of health matters to the Health Scrutiny Committee (HSC). Its terms of reference state that it will:

> *'undertake scrutiny of the planning, development and operation of Public Health and NHS services for citizens of West Berkshire, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'*

3.3 The HSC is responsible for reviewing or scrutinising services commissioned and provided by all relevant NHS bodies and health service providers. This includes GP practices and other primary care providers such as pharmacists, opticians and dentists, and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority, including Public Health services.

References to ‘health and wellbeing commissioners or providers’ in the remainder of this document is used as a term to include all public, private or voluntary organisations.

4. Understanding of the role of the scrutiny relationship:

4.1 All parties recognise the role of West Berkshire HSC in reviewing or scrutinising any issues relating to the commissioning and provision of health and wellbeing services to citizens of West Berkshire.

4.2 The bodies involved acknowledge the role of scrutiny in giving the public confidence of effective oversight of their health and wellbeing services. They also recognise the challenges facing the health and wellbeing system and that no single organisation can solve these alone.

4.3 HSC provides health and wellbeing commissioners and providers with a clear governance framework, transparency and a critical friend to help develop integrated solutions.

5 Application of the Protocol:

5.1 This Protocol sets out the process by which West Berkshire’s HSC (which represents the interests of West Berkshire Council and its citizens) will work with those bodies who commission and provide health and wellbeing services for the local population.

5.2 It covers health and wellbeing commissioners and providers under the Care Quality Commission (CQC) regulation, including:

- Treatment, care and support provided by hospitals, GPs dentists, ambulances and mental health services; and
- Services for people whose rights are restricted under the Mental Health Act.

5.3 Scrutiny of activities relating to the treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care) is the responsibility of the Overview and Scrutiny Management Commission.

5.4 The Protocol is a living document so can include those commissioners or providers who may be involved, now or in the future, in the planning, provision, or operation of health and wellbeing services. It applies to the resident population of West Berkshire and therefore accordingly where commissioners and providers are serving West Berkshire residents across the district boundary.

These commissioners and providers include (but are not limited to) the following:

- A34 Primary Care Network
- Kennet Primary Care Network

- West Berkshire Rural Primary Care Network
- West Reading Villages Primary Care Network
- Royal Berkshire NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- South Central Ambulance Service

5.5 Where necessary, joint health scrutiny committees may be formed across a different geography where a relevant body or service provider is required to consult more than one local authority's health scrutiny function about substantial reconfiguration proposals. West Berkshire has delegated powers for the scrutiny of the Integrated Care System to the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee.

5.6 This Protocol applies specifically to West Berkshire HSC activities, but it could be used as a good practice example around ways of working for any other committees discharging the functions of health scrutiny.

6 Shared goals and working principles:

6.1 Table 6.1 describes the shared goals and working principles by which all organisations covered by this Protocol will work.

Table 6.1: Shared Goals and Principles

Shared Goals
• Deliver high quality, sustainable health and wellbeing services that meet the needs of the West Berkshire population. • Improve the health and wellbeing outcomes for local people, including ensuring activity addresses health inequalities and aligns with the Berkshire West Health and Wellbeing Strategy.
Working principles
1. There is a "no surprises" approach between the organisations concerned. This builds collaboration whilst also allowing HSC to constructively challenge strategic decisions. 2. There is a climate of mutual respect and courtesy, noting one another's independence and autonomy. 3. Proposals and recommendations are based on appropriately sourced, recognised and clearly presented evidence. This includes relevant clinical evidence.

4. The views and priorities of local people should be gathered and considered in the development of proposals, in scrutiny and in decision making.

5. The overview and scrutiny approach is transparent, collaborative, constructive and non-confrontational. It is based on asking challenging questions and considering evidence.

6. There is recognition and respect for the difference which may arise around what constitutes 'best outcomes' for the local population.

7. Feedback from HSC to health and wellbeing organisations is documented and well communicated.

7 The 'no surprises' approach

7.1 In support of the first working principle, to have a 'no surprises' approach. The HSC forward plan is informed by and developed through regular dialogue with commissioners and providers. Involving HSC in discussions about proposed changes at an early stage will allow them to plan and scope their scrutiny reviews.

8 Service variations and assessing change

8.1 In circumstances where there are planned variations or developments to health and care services, relevant organisations will undertake to work in accordance with the working principles above to assess how significant the variation is.

8.2 The threshold at which a proposed variation or development is deemed 'substantial' is not precisely defined and an element of judgement is required. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

- Changes in accessibility of services.
- Changes to methods of service delivery.
- Impacts on service users and their families / carers.
- Impacts on health and social inequalities.
- Implications for service quality, deliverability and risk.
- The effects on other health services and the wider community

8.3 Table 8.1 describes and gives examples of the levels of change, variation or development which may occur in in health and wellbeing service for West Berkshire:

Table 8.1: Levels of change

Level	Category	Description	Example(s)	Action Required
1	Minor	When the proposed change would have a **minor** impact	A minor change in clinic times, the skill mix of particular teams, or small changes in operational policies.	The Committee would not routinely be notified or become involved.
2	Moderate	Where the proposed change would have a **moderate** impact, or where consultation has already taken place on a national basis	Rationalising or reconfiguring Community Health Teams. Policies that will have a direct impact on service users and carers. Changes that include the following may be considered substantial rather than moderate: • A reduction in service • A change to local access to service • Large numbers of patients being affected	The responsible commissioner notifies the Principal Policy Officer at an early stage. The Principal Policy Officer will liaise with the HSC Chairman and Vice Chairman to determine whether a fuller briefing is required in accordance with the Committee's stage one assessment process described below. The Committee will wish to ensure that the Healthwatch and other appropriate organisations are notified by the responsible commissioner or service provider concerned.
3	Substantial	Where the proposal has **substantial** impact and is likely to lead to: • A reduction or cessation of service • Relocation of service	Reconfiguration of GP Practices leading to practice closures. Centralisation of services, leading to closure of local clinics / treatment centres. Redevelopment / relocation of acute hospitals as part of HIP2 programme.	• The responsible commissioner(s) notify the Committee and formally consult the Committee. The Committee will expect to see formal consultation plans. The Local Ward Councillors concerned will be informed of the proposal. • The responsible commissioner(s) notify and discuss with the appropriate local authorities on service developments.

		• Changes in accessibility criteria • Local debate and concern		• The Committee consider the proposal formally at one of their meetings. • Officers of the responsible commissioners and service providers work closely with the Committee during the formal consultation period. • The Committee responds within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

Stage One

At the earliest possible stage, the health organisation responsible for the proposed change initiates dialogue with the HSC through the Principal Policy Officer.

The HSC Chairman and Vice Chairman are briefed on the proposed change.

The Chairman and Vice Chairman assess and determine the level of change using information gathered at the briefing and advice from officers. A recommendation and rationale is reported alongside the content of the briefing at the next formal HSC meeting for decision.

Stage Two

The organisation responsible completes the substantial variation assessment **(see Appendix A)**, gathering and presenting the relevant evidence.

The organisation responsible contacts the Principal Policy Officer to arrange an informal briefing with the HSC.

All HSC members should be sent detailed information regarding the proposals, including the completed 'substantial variation assessment'.

The organisation responsible should go through the assessment with HSC at the meeting and discuss whether they believe the proposed service variation or development is 'substantial'. A recommendation and rationale will be reported alongside the content of the briefing at the next HSC meeting for decision.

All HSC members and the health organisation responsible should be informed of the outcome of the meeting and given a record of the meeting.

Final Say

8.6 Should there still be disagreement over whether a service change or variation is substantial at the end of a stage two assessment; it is the view of HSC which prevails. The HSC view therefore determines whether a service variation is substantial and requires commissioners to consult.

Exemptions

8.7 The following are circumstances where the HSC will not need to be consulted:

- Proposals to establish or dissolve an NHS trust or CCG if this does not represent a substantial development or variation to the provision of health services.

- Proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997, as these are the subject of separate legislation.

- Where a decision has to be taken immediately because of a risk to the safety or welfare of patients or staff. These circumstances should be anticipated and reported in advance, making unanticipated situations the absolute exception. The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how patients and carers have been informed about the change and what alternative arrangements have been put in place to meet the needs of patients and carers.

9. Consulting with the Committee

9.1 As identified in the table above, where a 'Level 3' or substantial service variation is identified, the responsible commissioner(s) will notify the Committee and formally consult the HSC. This is in addition to discussions between the responsible commissioner(s) and the appropriate local authorities or Health and Wellbeing Boards on service developments. It is also additional to the NHS duty to consult patients and the public.

9.2 The HSC has the responsibility to consider and comment on:

- Whether as a statutory body the HSC has been properly consulted (in addition to the public consultation process).

- The adequacy of the consultation undertaken with patients and the public.

- Whether the proposal is in the interests of health services in the area.

9.3 The HSC may refer proposals for substantial service developments or variations to the Secretary of State where it is not satisfied that:

- Consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed.

- The proposal would be in the interests of the health service in West Berkshire.

- A decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate.

Appendix A:
Substantial Change Assessment Form

NAME OF RESPONSIBLE BODY:

CONTACT INFORMATION:	
Name: **Job Title:** **Address:** **Email:** **Telephone**:	

SECTION A: BACKGROUND INFORMATION
Proposed service change: Brief description of the proposal, including whether it involves: an increase / decrease / introduction / withdrawal of service; changes to hours of operation; relocation; changes to methods of service delivery. Also indicate if the proposed change will be permanent or temporary.
Rationale for the proposed change: All key drivers for the proposal.
Strategic fit of proposal: Consider this at national, system and place level.
Date by which final decision is expected to be taken:

SECTION B: CONSULTATION / STAKEHOLDER ENGAGEMENT
Legal Obligations: Have the legal obligations set out under Section 242 of the consolidated NHS Act 2006 to 'involve and consult' been fully complied with?
Yes / No (delete as applicable) **Commentary:**
Stakeholder Engagement: Have initial responses from service users, their carers / families / advocates, and from Healthwatch indicated whether the impact of the proposed change is substantial?
Yes / No (delete as applicable) **Commentary:**
Stakeholder Support: Is there any aspect of the proposal that is contested by key stakeholders? If so what action has been taken to resolve this?
Yes / No (delete as applicable) **Commentary:**
Staff Engagement: Have staff delivering the service been fully involved and consulted during preparations of the proposals? If so how?
Yes / No (delete as applicable) **Commentary:**
Staff Support: Is there any aspect of the proposal that is contested by the clinicians / other staff? If so what action has been taken to resolve this?
Yes / No (delete as applicable) **Commentary:**

SECTION C: PATIENT IMPACT
Improvement: How will the proposed change deliver improved clinical and social outcomes for patients and improved patient experiences?
Commentary:
Service Users: How many people are likely to be affected by the proposal and which areas are the affected people from?
Commentary:
Inequalities: Does the proposed change of service have a differential impact that could create new / widen existing inequalities (geographical, health, social, etc)?
Yes / No (delete as applicable) **Commentary:**
Patient Access: Will the proposed change affect patient access in terms of location, transport access (public and private), travel time, etc?
Yes / No (delete as applicable) **Commentary:**
Incremental Impact: Does the proposal appear as one of a series of small, incremental changes that when viewed cumulatively could be regarded as substantial?
Yes / No (delete as applicable) **Commentary:**

SECTION D: SERVICE QUALITY, DELIVERABILITY AND RISK
Proven Practice: What is the strength of evidence about the clinical performance of the proposed change?
Commentary:
Service Capacity: Will the proposal result in sufficient capacity to meet demand, taking account of aspects such as demographic changes, changes in morbidity / incidence of relevant conditions, or reductions in care needs due to improved screening?
Yes / No (delete as applicable) **Commentary:**
Workforce implications: Have the workforce implications associated with the proposal been assessed?
Yes / No (delete as applicable) **Commentary:**
Financial Implications: Have the financial implications of the change been assessed in terms of capital and revenue and overall financial sustainability?
Yes / No (delete as applicable) **Commentary:**
Risk: What are the key risks associated with the proposal and how will these be managed?
Commentary:

SECTION E: WIDER IMPACTS
Community Impacts: What are the wider impacts on affected communities (e.g. environmental, transport, housing, employment, etc)?
Commentary:
Service Impacts: Will the proposed changes affect: a) services elsewhere in the NHS; b) services provided by local authorities; c) services provided by the voluntary sector?
Yes / No (delete as applicable) **Commentary:**

OUTCOME / DECISION
Is this considered to be a substantial service change or development by the commissioner / provider?
Yes / No (delete as applicable) **Commentary:**
Is this considered to be a substantial service change or development by the Health Scrutiny Committee?
Yes / No (delete as applicable) **Commentary:**

Possible Outcomes

Consultation is required

- If the health organisation and the Health Scrutiny Committee representatives agree that the proposal does represent a substantial service change or development, the formal consultation with the Health Scrutiny Committee will commence.
- The Health Scrutiny Committee must be provided with:
    - The date by which the responsible organisation intends to decide whether to take the proposal forward.
    - The date by which the responsible organisation requires the Health Scrutiny Committee to provide any comments. (It is expected that any formal consultation would be undertaken by the commissioner of the service.)

Consultation is not required:

- If the health organisation and the Health Scrutiny Committee representatives agree that the proposal does not represent a substantial service change or development, then formal consultation with the Health Scrutiny Committee is not required.
- Best practice is that the health organisation should continue to engage scrutiny and the public in the development of the proposal and onwards to public consultation in accordance with Section 242 requirements.

Agreement cannot be reached:

- If agreement cannot be reached between the health organisation and the Health Scrutiny Committee representatives, then all reasonable, practicable steps should be taken towards local resolution.
- Further meetings may be conducted with the wider Health Scrutiny Committee members and other stakeholders such as Healthwatch, carer/user groups, and the voluntary sector.
- If it continues to be impossible to reach agreement, both sides may jointly or independently pursue the options open to them under their respective statutory instruments, such as escalation to the Secretary of State or to the provider's Board.

NB: Health Scrutiny Committee representatives may prefer not to make a final decision about whether formal consultation is required at the meeting and choose to notify the organisations involved once a decision is made.

Note on Consultation Processes

The Department of Health's (DH) Local Authority Scrutiny Guidance (2014) states the following in relation to consultation processes:

> *"The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS*

should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed."

It is therefore understood that the process of assessing substantial change should take place as part of broader meaningful engagement with local communities.

The relevant health organisation is responsible for engaging and consulting all relevant local people. It is expected that this will include locally elected representatives where the service change will have an impact (parish / town council, district council and MPs).

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Health Scrutiny Review Matrix

Review Topic: Healthcare provisions in new developments	**Timescale:** **Start: July 2022** **Finish: tbc**

Review Rationale:

A key concern of proposed new developments is around adequate healthcare provisions. Ensuring the right healthcare facilities are provided to serve new housing developments is essential. There is a need to ensure that health commissioners are adequately consulted on requirements for health facilities to serve new developments and that developers engage with health commissioners to provide those facilities.

Considerations of the review would include:

- Form an understanding of the process for considering the healthcare provisions needed for large, new developments and incremental developments including S106 and CIL
- Gather the experience of key stakeholders: community, developers, healthcare providers
- Analyse examples of good practice
- Consider the strengths and constraints of current arrangements
- Develop recommendations for improving future effectiveness in the process

Terms of Reference:

The Task and Finish Group will:

1. Form an understanding of the process for reviewing the healthcare provisions needed for new developments (large and incremental) and how West Berkshire Council engage and consult with health bodies.
2. Form an understanding of how West Berkshire Council secures CIL and S106 (developer contributions) and how it is made available to health bodies for healthcare facilities.
3. Form an understanding of how the Integrated Care Board (ICB) and GP Practices engage with the planning process of proposed developments.
4. Form an understanding of how developers work with health bodies in meeting the healthcare provision needs of new developments.
5. Collect evidence from stakeholders on their experience of engagement with the process of new developments in the context of healthcare facilities. These could include the community, developers, Local Planning Authority and healthcare providers (ICB and Primary Care Networks)

6. Review what the strengths and constraints are of current arrangements for the stakeholders.
7. Consider how the new 'Infrastructure Levy' may impact on healthcare provisions in new developments.
8. Develop recommendations for improving effectiveness in the process.

Members will collate their findings which will then form the basis of a report to be considered by the Health Scrutiny Committee.

Review Membership:

Membership of the Task and Finish Group will be agreed by the Health Scrutiny Committee on 14 June 2022.

Councillor
Councillor
Councillor
Councillor

Chairman: TBC

Vice-Chairman: TBC

Lead Officer: Vicky Phoenix

Information Required:

- Information on CIL and S106 processes
- Information on engagement processes by planning with health bodies
- Interview with ICB on engagement practices with planning and developers.

Witnesses:

- West Berkshire Council Planning Officers
- Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board
- Representatives from Primary Care Networks

Health Scrutiny Committee – 14 June 2022

Item 11 –Task & Finish Group Updates

Verbal Item

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Health Scrutiny Committee Work Programme

The following items will be considered in addition to Standing Items: Updates from Task and Finish Groups

Last Updated: 6 June 2022

Ref	Item	Purpose	Health Body	Prioritisation Score
14 June 2022 (Report Deadline 3 June)				
6	Facilities for New Developments	To agree Terms of Reference for a Task and Finish Group to look at the provisions of healthcare serving new developments.	Berkshire West CCG	11
7	Thornford Park Hospital	To provide an update on the response to the Care Quality Commission report and plans for future investment.	Elysium Healthcare No.2 Limited	12
8	Cancer Treatment	To provide an update on current performance re. waiting times and referrals, and the mitigation measures introduced.	Royal Berkshire NHS Foundation Trust	11
13 September (Report Deadline 2 September)				
9	South Central Ambulance Service	To present an overview of current performance re. response times and hospital transfers, and winter service plans for 2022/23.	South Central Ambulance Service	11
10	Westcall Out of Hours Care	To present an overview of demand in urgent and unscheduled out-of-hours calls. Consider response and issues arising.	Westcall / Berkshire Healthcare NHS Foundation Trust	11
13 December 2022 (Report Deadline 2 December)				
11	Covid Reponse	To agree the Terms of Reference for a Task and Finish Group to look at the ongoing impact of Covid on health services and treatments.	Berkshire West Clinical Commissoining Group (CCG) / Royal Berkshire NHS Foundation Trust	12
14 March 2023 (Report Deadline 3 March)				
Other Items to be programmed				
12	Hospice Provision	To review hospice service provision for residents of West Berkshire, including the palliative care hub in Newbury.	Sue Ryder	tbc
13	Blood Tests	To review patient access to phlebotomy services	Royal Berkshire NHS Foundation Trust	10
Standing Items				

	Berkshire West Clinical Commissioning Group Update	To receive an update from the Berkshire West Clinical Commissioning Group on their activities.	Berkshire West CCG	N/A
	Healthwatch West Berkshire Report	To receive an update from Healthwatch West Berkshire on patient feedback received, reports prepared and other activities.	Healthwatch West Berkshire	N/A