Care Quality Commission

Independent Health provider well-led assessment

Coveberry Limited

Date of inspection: 15 November to 27 November 2023

Date of publication: 27 February 2024

Our findings

Overall summary

Inspected but not rated

This report describes our judgement of the quality of care given by this registered provider of health and social care. It is based on a combination of what we found when we carried out a reactive provider well-led assessment, information from our monitoring system, and information given to us from people who use services, the public and other organisations. The assessment focused on how well-led the organisation is, looking at leadership and management, governance, quality assurance and continuous improvement, to ensure the delivery of safe, high-quality services.

We have not rated this provider as part of this assessment as this is not part of the current methodology for independent health care providers.

Overall Summary

The provider had not always achieved regulatory compliance at its hospitals. It had taken considerable time after the acquisition of its hospitals for leaders to understand and address the challenges at these locations.

The provider had not acted promptly to address poor cultures. Instances of poor culture, where services had failed to protect patients from abuse, had been treated in isolation.

Staff working within the services had little awareness of the role of the freedom to speak up guardian.

Initiatives to promote equality, diversity and inclusion for staff were insufficiently developed.

At a senior level, governance and decision-making was not consistently recorded. Although staff escalated governance information, they received little feedback or information from senior levels of the organisation.

The provider did not always ensure there were sufficient arrangements in place to identify and address risks within its services. The decision to close a hospital at the time of the inspection had not fully considered the personal and clinical impact on patients.

There was little co-production or engagement with patients and their families in decisions about the strategy and development of services. Feedback from patients and service users was not routinely sought or reviewed at governance meetings.

There were insufficient measures in place to improve the quality of services. There were plans in place to introduce quality improvement methodology to the services, but these plans were at an early stage.

However:

Leaders had experience, capacity, capability and integrity. Leaders at a divisional level were visible and approachable. Leaders were knowledgeable about issues and priorities for the services.

Staff, managers and leaders were committed to person-centred care. They took pride in achieving positive outcomes for patients and service users.

Staff said that during the last year, there had been considerable improvements in the support they receive from senior colleagues. They said they would be confident in raising concerns about poor practice.

There had been significant improvements in the governance at a divisional level over the last year. There was a clear structure of committees and sub-committees that followed standard agendas. Governance meetings reviewed performance data that was clear and easy to understand.

The provider had sufficient oversight of the use of the Mental Health Act at a divisional level.

Financial risks were managed well.

Data and notifications were submitted to external agencies.

Background

Coveberry Limited provides four hospitals and seven adult social care services. It sits within the Adults and Specialist Services directorate of CareTech, an international provider of services to adults and children with complex needs. CareTech was set up by two of the current directors in 1993. Over the last 30 years, CareTech has grown considerably. It now manages 550 residential homes and specialist services in the UK, including specialist services for adults with autism, acquired brain injury, learning disabilities and mental illness. Overall, Coveberry comprises of 2% of the CareTech group.

Coveberry expanded its portfolio considerably in 2020. Coveberry acquired four hospitals, two nursing homes and single accommodation units, most of which had formerly been part of Huntercombe (Granby One) Limited, owned by Four Seasons Healthcare.

Following these acquisitions, Coveberry struggled to make the necessary improvements to ensure regulatory compliance at these hospitals. Eldertree Lodge was a hospital for up to 41 patients

providing specialist inpatient treatment and long-term high dependency rehabilitation services in locked wards specifically for patients with a learning disability or autism. It closed in July 2021 after two Care Quality Commission (CQC) inspections rated the services as inadequate. During 2022, both Cedar House and Uplands Independent Hospital were rated as inadequate and placed in special measures. In 2023, the rating for the hospital at Oldbury, Birmingham went from good to requires improvement. Following inspections in 2023, the ratings for Cedar House and Uplands were raised to requires improvement and the services came out of special measures.

During the same period, inspections of Coveberry's social care services have been awarded ratings of good or outstanding. Inspections at Cedar Bungalows in 2023 and Oakwood House in 2022 found the services to be good. An inspection of Redbourne in 2022 found the service to be outstanding. Sherwood had been rated as outstanding since its inspection in 2018, when it was still run and managed by Huntercombe. All Hallows Neuro Rehabilitation Centre was registered with Coveberry on 27 June 2023. The service had been acquired from Oakleaf Care (Hartwell) Limited, another organisation owned by CareTech. The last inspection of All Hallows took place in April 2023, when the service was managed and run by Oakleaf. Following that inspection, service was rated as good.

In September 2023, Coveberry announced that it would be restructuring its services. This will involve changing the services at Cedar House, the Willows and Uplands Independent Hospital to nurse-led residential care services.

At the time of the inspection, Coveberry Limited was registered with the Care Quality Commission to provide care across 11 locations. This included 4 hospitals and 7 adult social care locations. The Willows and Uplands Independent Hospital provided long stay or rehabilitation wards for adults of working age. Cedar House provided wards for people with learning disabilities or autism. The hospital at Oldbury, Birmingham provided both wards for people with learning disabilities and autism and long stay or rehabilitation wards.

At the time of our inspection, the overall breakdown of Care Quality Commission ratings for the 11 locations was as follows:

Hospitals	• **Registered activities**	**Current overall rating**
Cedar House	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Diagnostic and screening procedures • Treatment of disease, disorder or injury	Requires Improvement
Oldbury Birmingham	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Diagnostic and screening procedures • Treatment of disease, disorder or injury	Requires Improvement
The Willows	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Treatment of disease, disorder or injury	Requires Improvement
Uplands Independent Hospital	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Diagnostic and screening procedures	Requires Improvement

	• Treatment of disease, disorder or injury	
Adults Social Care		
66 Park Lane	• Accommodation for persons who require nursing or personal care	Good
All Hallows Neuro Rehabilitation Centre	• Accommodation for persons who require nursing or personal care • Treatment of disease, disorder or injury	Good
Cedar Bungalows	• Accommodation for persons who require nursing or personal care	Good
London Road DCA	• Personal care	Service has not been inspected
Oakwood House	• Personal care	Good
Redbourne	• Accommodation for persons who require nursing or personal care • Treatment of disease, disorder or injury	Outstanding
Sherwood	• Accommodation for persons who require nursing or personal care • Treatment of disease, disorder or injury	Outstanding

Analysis of the ‘must do’ actions in the CQC reports for all inspections of Coveberry services between June 2021 to July 2023 found there were a total of 90 breaches of regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were:

- 32 breaches of Regulation 12: Safe care and treatment
- 19 breaches of Regulation 17: Good governance
- 16 breaches of Regulation 9: Person-centred care
- 12 breaches of Regulation 18: Staffing
- 5 breaches of Regulation 15: Premises and equipment
- 4 breaches of Regulation 13: Safeguarding
- 2 breaches of Regulation 10: Dignity and respect

All the breaches related to the 5 hospital locations. There were no breaches of regulations at the adult social care locations.

We carried out analysis of issues identified in 3 Mental Health Act monitoring reports and 1 thematic seclusion review that took place between 28 September 2021 and 2 June 2023 at Coveberry locations registered to provide assessment or medical treatment for people detained under the Mental Health Act 1983. Within these reports, there were 27 concerns about the implementation of the Code of Practice. Of these:

- 13 related to empowerment and involvement
- 10 related to purpose and effectiveness
- 2 concerned least restrictive practice

Six patients had raised concerns with Mental Health Act reviewers. These related to physical health monitoring, engagement with family members, discharge planning and a request to have more time with staff.

All locations had a registered manager in post.

Our inspection team:

The onsite inspection team included a deputy director for mental health, two senior sector specialists for mental health, and an operations manager and an inspector who held a specialist portfolio of independent health providers.

The team was advised by a governance lead and an executive reviewer who were senior leaders in their own organisations. The governance lead had a professional background in nursing and had worked at an executive level in a large health care provider. The executive reviewer had a professional background in accountancy in health services and had held executive roles.

How we carried out the inspection

We carried out the following activities as part of this well-led assessment:

- Reviewed information held by the CQC in relation to Coveberry services.
- Conducted a focus group attended by 13 staff who worked at Coveberry services. These staff included nurses, support workers and therapists.
- Conducted a focus group with 7 managers of Coveberry services.
- Interviewed 14 leaders within CareTech who had oversight and responsibility for Coveberry services.
- Received feedback on the services from 8 commissioners.
- Reviewed documents relating to the running of the service including records of governance meetings, safeguarding concerns, complaints, records of incidents and staff records.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Why we carried out this inspection

We conducted this well-led assessment of Coveberry Limited as part of our risk-led schedule of independent health provider well-led assessments. Coveberry Limited was selected due to its inherent risk of caring for a range of vulnerable people with complex care needs. We noted that all four hospital locations were rated as requires improvement. Two of these hospitals had recently been rated as inadequate.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider 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 provider MUST take to improve*:**

The provider must ensure that it fully understands and mitigates any risks associated with both established and newly acquired services. (Regulation 17: Good governance)

The provider must ensure there is clear evidence of executive level oversight of adverse incidents and that it acts promptly to address risks to the safety of patients. The provider must analyse incident reports, identify themes, assure itself that patient safety themes are being addressed and share learning from investigations across the organisation. The provider must also ensure that it's systems for measuring key performance indicators did not discourage staff from reporting adverse incidents.

(Regulation 12: Safe care and treatment)

The provider must there is full connectivity of governance from hospitals to divisional leadership and to the overall board, ensuring oversight and decision-making is visible at all levels. (Regulation 17: Good governance)

The provider must ensure that people using its services and their families are fully involved in decisions about moving to alternative placements, and that sufficient time is given for the process to take place. (Regulation 9: Person-centred care)

The provider must ensure that it seeks, and act upon, feedback from patients, service users and their families for the purposes of continually evaluating and improving its services. (Regulation 17: Good governance)

The provider must ensure it has oversight of diversity, equality and inclusion of patients and service-users, and use this information to make tangible changes to how equality and inclusion are understood and promoted as part of the culture of the organisation. (Regulation 10: Dignity and respect)

The provider must develop and embed its quality improvement approach and ensure this is widely embedded. (Regulation 17: Good governance)

The provider must ensure it provides a full apology and explanation to patients when things go wrong. (Regulation 20: Duty of Candour)

The provider must ensure that executive leaders have oversight of diversity, equality and inclusion of staff and use this information to make tangible changes to how equality and inclusion are understood and promoted as part of the culture of the organisation. (Regulation 17: Good governance)

The provider must ensure that comprehensive records are held for all executive directors to ensure that directors meet appropriate standards of character, experience and competence. (Regulation 19: Fit and proper persons employed)

The provider must ensure there are effective arrangements to ensure staff are aware of the freedom to speak up guardian and that this role is used appropriately. (Regulation 17: Good governance)

Action the provider SHOULD take to improve:

The provider should ensure that it monitors themes and trends within complaints and ensures these are shared with services so that they can make improvements.

The provider should ensure that the processes for identifying and addressing risks from the services are strengthened. Senior leaders should know and be able to articulate the top corporate risks. There should be clear timescales and actions for mitigating risks and progress should be monitored.

The provider should ensure that all senior leaders can understand and clearly articulate the strategy for the organisation.

The provider should ensure that it strengthens its assurance systems to identify and address closed cultures.

The provider should ensure is has a well-being strategy in place for its staff.

The provider should ensure that it continues its work to improve the monitoring the use of restrictive interventions at governance meetings.

The provider should ensure that staff have access to prompt support with information technology.

Is this organisation well-led?

Inspected but not rated

We did not rate the provider at this inspection.

Leadership

Coveberry Limited sits within the ‘Adults and Specialist Services Division’ of CareTech. Throughout this assessment, we have focused on the management and leadership of Coveberry which is provided through this division. Leaders at this level are referred to as divisional directors, comprising of the head of governance, performance director, operations director and group medical director. The divisional leadership group reported to the executive director for adult and specialist services who was a member of the executive leadership. They are referred to in this report as the divisional executive director. To understand the relationship between Coveberry and the systems and processes for the wider organisation, we also refer to senior leaders within CareTech. These leaders are referred to as the executive leadership, and comprise of the chief executive, group executive director for compliance and quality, group executive director for marketing, group human resources director and the chief financial officer.

Members of the executive leadership team at CareTech had an extensive range of skills, knowledge and experience in the delivery of social care services, along with experience and qualification that were specific to the role. The chief executive officer had founded CareTech in 1993. They were highly committed to the success of the business and passionate about the work CareTech did to support the people using its services. They had an excellent knowledge of services across the CareTech portfolio.

The divisional leadership team also had an appropriate range of skills, knowledge and experience. This team had been strengthened in April 2022 with the appointment of a group medical director.

This followed a 7-month gap in which there had been no clinical leadership of Coveberry's hospitals, either through a medical director or director of nursing. The divisional executive director had worked for CareTech for 10 years. The group medical director had worked as a consultant neuropsychiatrist for over 10 years. During that time, they had chaired an advisory group for the Royal College of Psychiatrists Quality Network. The operations directors and the head of governance were both registered mental health nurses. Other directors all had experience of working in management roles, predominantly in services for people with learning disabilities and autism. The provider did not employ a director of nursing. The functions of this role largely rested with the operations directors. Hospital managers said that operational directors were very experienced and knowledgeable, and this meant they could be very supportive.

The executive leadership team were able to describe their portfolios and areas of responsibility and reflect on areas of potential risk. They had a good understanding of the principles around quality, people and the commercial objectives that underpinned their work. Executive leaders explained that the quality of services was based on ensuring safety and having a clear focus on patients. They told us about the critical risks and challenges, such as ensuring they had the right staff in post. Executive leaders were aware that there had been gaps in the governance of services and they were working to address this.

Divisional directors were able to articulate significant facts and figures relating to their portfolio. Directors had a good grasp of data relating to staffing, agency use, turnover, and occupancy at each of their services. The Performance Director and Head of Finance produced a monthly business review document setting out performance data relating to CQC ratings, staffing, occupancy, budget meeting actions, and variance to budget forecasts.

The divisional executive director had been in post for two years. When they began in the role, they recognised that improvements were needed to ensure leaders were more visible to staff, to address the risk of closed cultures and to encourage staff to be able to speak up about concerns. They also felt that services tended to be working in silos. They explained that services had lacked a shared understanding of what they were trying to achieve and a common approach to managing their work. They had made changes to the leadership within the division and implemented urgent improvements to services to address concerns highlighted by the CQC.

The divisional directors carried out regular visits to sites across the organisation. They recognised that difficulties with organisational cultures had contributed to the poor performance of some of the hospitals. They sought to address this by frequently visiting the hospitals to build trust and engage with staff and patients. They sought to role-model good leadership and demonstrate their commitment to caring for patients. The group medical director had carried out support worker shifts, including enhanced observations of patients, at hospitals in order to get to know staff and understand the needs of patients. Divisional directors provided examples of how services had improved after they had provided enhanced support. Staff at one hospital told us that the executive director had visited their service and engaged well with patients to understand their emotional needs and challenges. The board held some of their meetings at their services to provide an opportunity to engage with staff and patients.

The executive leadership had sufficient capacity to oversee the delivery of high-quality care and treatment. The full board of CareTech met every three months. At the time of the inspection, the leadership team for Coveberry had been working together 12-15 months. They felt they had developed well as a team during that time and created a good relationship with operational

colleagues. They said that the team worked well and supported each other to ensure there was sufficient capacity to oversee the services.

Leaders at both and executive and divisional level felt supported by colleagues. They said they were able to talk to colleagues about any difficulties in an open and honest manner. Executive directors typically met with the chief executive for an hour every two weeks. They felt their objectives were clearly defined. The chief executive said they valued the support and trust they had with colleagues, particularly colleagues who had been with the organisation for many years.

Clinical leadership was the responsibility of the divisional group medical director. They provided clinical supervision to the clinical leads at each service and the four doctors that Coveberry employed. Their other priorities were to understand and develop the existing governance systems, processes and lines of accountability. They had also been involved in supporting the rapid improvement of services that had been placed in special measures.

Coveberry Limited had systems in place to ensure their executive team had the necessary fit and proper person checks, although the quality and amount of information held on human resources records for directors varied. For directors who recently had joined the company, their records contained a curriculum vitae, references, contract of employment and a fit and proper persons declaration. For directors who had been with the company a long time, there was very little information. We looked at 8 records. Four of these records contained a data and baring service (DBS) certificate. A new DBS application has been made for the other four directors.

Divisional directors were able to describe how they were addressing the challenges they faced and working to provide a high standard of care. For example, directors were able to describe how the services were responding to changes in commissioner's priorities, moving away from the model of locked rehabilitation services that Coveberry provided at some of its hospital sites. Whilst directors were keen to move towards a model of nurse-led residential care, they were aware of challenges involved in providing alternative provision for patient's subject to restrictions overseen by the Ministry of Justice.

The provider employed experienced service managers at each location. Directors said they had confidence in the service managers, and they were proud of the team they had created. Most of the service managers were registered nurses.

Divisional directors and the executive leadership felt there was a need to improve career pathways through the organisation. Their ambition was to improve retention and have more leaders who had worked their way up from less senior positions. Staff were able to give many examples of internal promotions, including nurses who joined the organisation at an early stage of their career and become hospital managers.

Divisional directors engaged in opportunities for their own learning and development. Directors said they kept up to date with their own learning and development through membership of professional networks. The group medical director continued to practice as a neuropsychiatrist within the NHS for two days each month.

The provider had embedded succession planning. The chief executive had considered the arrangements for succession. The were keen to ensure that any succession took place at an appropriate time.

Professional leadership across the organisation was facilitated through supervision and support groups. The service employed a relatively small number of health and social care professionals. There were 71 registered nurses, 4 doctors and social workers. Nurses said that their hospital directors provided professional support and supervision. This was supported by a senior nurse advisor. There were group supervision sessions arranged for allied health professionals. A nursing forum took place once a month. The provider had appointed an external consultant as the professional lead for the two social workers.

Vision and Strategy

All CareTech services had a shared set of vision and set of values, focused on being friendly, positive, innovative empowering and person-centred. Whilst staff and directors struggled to articulate a clear vision or set of values, they clearly had a desire to provide good quality, person-centred services and create a supportive culture in teams that were committed to the people using their services. CareTech branding promoted the 'Extraordinary Days Every Day' initiative to highlight the achievements of people using their services. This was a positive way of promoting the organisations vision and purpose of enabling children, young people and adults with complex needs to make their own life choices, develop confidence and build a better future.

The immediate strategic plan for Coveberry was to restructure its services. This included moving out of the provision of hospitals. Divisional directors explained that the priorities of commissioners were changing, meaning that the model of locked mental health rehabilitation services was becoming less commercially viable. They also cited specific challenges at their hospitals, such as difficulties in recruiting staff to hospitals in isolated areas.

On 1 October 2023, two of Coveberry's social care services had been transferred to a different division in CareTech. The model of care was being reviewed at three of the four hospitals sites, with a view to providing nurse-led care homes instead of hospitals.

The human resources department was working toward strategic objectives. These included improving consistency of performance, improving the induction process, improving the use of staffing data and improving career pathways. The human resources director recognised that services were dependent on agency staff. They were aiming to improve the consistency of staff by block booking agency staff and offering incentives for agency staff to become full time employees.

The provider had a quality strategy. CareTech had published a quality account for 2022/23 which set quality objectives. These focused on assurance and improvement, clinical governance, creating a learning organisation, safety and corporate risk management.

The provider had an environmental, social and governance strategy which outlined its ambition to deliver care in a more sustainable way. CareTech had published its environmental, social and corporate governance update in its Purpose Report 2022. This included data on greenhouse gas emissions, land use, ecological sensitivities and water consumption.

We received feedback from eight commissioners. Feedback from most commissioners was positive, although one commissioner was concerned about the sudden closure of a hospital. Commissioners were consistently positive in their view of the changes that had taken place across Coveberry services since summer 2022. The commissioners gave examples of where services had managed and supported complex patients well. They all said that communication with the services was very good. However, the commissioners for one service explained that they were

ending their contract with the hospital and referred to concerns set out in CQC reports. We spoke with three commissioners who had placed patients in hospitals that were closing. One commissioner explained that Coveberry had given over six months' notice of the closure. They said the process of moving patients to other hospitals was being safely managed within a collaborative process. The commissioner for another service said they had received only one-months' notice of closure. They said that moving a patient at such short notice was difficult and disruptive for the patient and likely to have an adverse impact on the patient's mental health. They explained that the person they placed was having to move 200 miles to an entirely different and unfamiliar part of the country.

Culture

Coveberry directors placed a high importance on the values they were seeking to embed within the organisational culture. Divisionals directors and executive leaders across the organisation demonstrated a caring person-centred approach to their work and took pride in the positive outcomes they achieved for patients and service users. They said that a person-centred ethos was the most important quality they looked for when recruiting new staff.

Staff we spoke with in focus groups and through interviews reported a positive culture within the organisation. Staff said they found the organisation to be friendly. They said that the operations manager, the medical director, and head of governance were all very approachable, responsive and supportive. In particular, they noted that senior leaders had become more open and transparent in the 6 to 8 months before the inspection, sharing minutes of divisional leadership meetings. Night staff said they received good communication from managers, enabling them to feel engaged in plans for the services. However, staff said that major changes in the organisation were difficult. Significant changes to three of the hospitals had been announced to staff shortly before this assessment. Hospital managers had worked with the senior management team to conduct briefing sessions and information to staff to avoid any rumour or speculation about the future. Despite these efforts, staff still felt the announcement had caused high levels of anxiety and, at some services, staff morale was low. Staff were worried about job security. They also said that responses to concerns they had raised were not always delivered clearly and they tended to hear about specific concerns indirectly. At some hospitals, formal consultations with staff about the future of services had begun.

Staff knew how to raise a concern, although there was limited awareness of the freedom to speak up process. Staff said they felt able to speak up and challenge the way things are done at work. They said they would speak to the person in charge of their shift or the hospital director if they had any concerns. They said they would feel comfortable in escalating any concerns to the operations director or the group clinical director if they felt their concerns were not being addressed.

The provider had a speak up policy although very few staff had used this policy. Staff were aware that a whistleblowing policy was in place. CareTech had a telephone number available 24-hours each day that staff could use to report whistleblowing concerns. However, directors said that this telephone service was mostly used by staff to raise practical concerns, such as reporting that they had not received their payslip. They said that whistleblowing concerns were rare. This view was consistent with data showing that only 4 of 48 calls to this telephone line since January 2023, had been classified as whistleblowing.

The provider had appointed a dedicated freedom to speak up guardian. The group executive director of compliance and quality held the role of freedom to speak up guardian. However, staff had little awareness of who the freedom to speak up guardian was, or what the person's role was. Data showed that only one person had contacted the freedom to speak up guardian in 2023.

Prior to the appointment of the group medical director in April 2022, the provider had not responded adequately, or acted consistently across its hospitals, to address closed cultures. In August 2021, the service was forced to close Eldertree Lodge after a CQC inspection found ill treatment and abuse of patients. During interviews, staff explained that these concerns were treated entirely in isolation and there was no attempt to explore how the risk of similar abuse in other settings could be avoided. Subsequently, a CQC inspection of Uplands in January 2022 found that staff had laughed at patients and not responded to requests for help. During that inspection, patients said that staff did not always treat them well and some patients said they did not feel safe. Also in January 2022, the CQC found that some staff offered only minimal levels of engagement with patients. Staff said that there had been some improvements over the last year, but the services still lacked a systematic approach to identifying and addressing closed cultures.

Coveberry took limited steps to promote equality, diversity and inclusion for its staff and service users. Training on equality, diversity and inclusion was part of the induction and mandatory training. The directors had ambitions to improve equality, diversity and inclusion across the organisation. This ambition was set out in the Management Development Plan. However, there were no specific programmes of work to develop diversity and inclusion. For example, there were no networks of forums for staff from minority ethnic groups or lesbian, gay or transgender staff.

The provider had collected data about the protected characteristics of their staff or service users. Between 30-35% of staff were from minority ethnic backgrounds. Overseas staff comprised of about 10% of the Coveberry workforce. However, directors felt that more needed to be done on collecting data, especially relating to the ethnic background of patients. For example, directors said that some work may have been taking place to analyse the ethnic background of patients subject to restrictive interventions, but this had not been included in data presented to clinical governance meetings.

Staff said the organisation acted fairly towards staff regardless of their ethnic background, gender, religion, sexual orientation, disability or age, although there were no specific initiatives in place to monitor this. For example, the organisation did not monitor the ethnic backgrounds of staff who were subject to disciplinary investigations. The provider had recently recruited a cohort of nurses and support workers from other countries. They had provided specific support for these staff including paid accommodation for one month and an intensive mentor to provide support both at work and outside work. This included monthly meetings with the overseas staff liaison office for the first three months of their employment. Staff said these arrangements had worked well and the new staff had now settled into their teams.

The provider did not have a specific Equality, Diversity and Inclusion strategy. CareTech's 'Purpose Report' for 2022 stated that by 2023 it will develop an Equality, Diversity and Inclusion Strategy Framework to ensure inclusiveness and fairness in how it operates. This work had not been completed. However, the report included data showing that 70% of staff were female. Data on the ethnic backgrounds of staff showed that 8.26% of staff were for an Asian background and 10.15% were Black or Black British. However, this data only covered 60% of staff.

The provider did not have a staff wellbeing strategy in place, but it did take steps to support staff who were having difficulties. Managers could authorise extended leave to staff. The CareTech Foundation could, in some situations, provide financial support to staff. Staff could contact a 24-hour support service that provided counselling and legal advice.

Coveberry had identified recruitment and retention as a high risk. To address this, it was introducing a scheme for recruiting overseas workers, improving nurses’ contracts of employment, providing relocation packages and introducing recruitment bonuses.

The provider did not have a dedicated workforce strategy and committee. Matters relating to the workforce were reviewed and discussed in governance meetings.

Turnover across the organisation was moderate. The turnover rate within the division for the 12 months to September 2023 was 21%. The turnover rate for registered nurses was higher at 36%.

Coveberry had improved the delivery of learning and development for its staff. In the last 12 months, the provider had reviewed its training and unified its programme of mandatory training for all staff. Hospital directors said there was a strong culture of staff development across the organisation. Non-clinical staff completed care certificate programme of training. Staff said there was a pathway for support workers to become senior support workers, and then to complete nursing practitioner training. The provider offered staff the opportunity to complete the National Vocational Qualification Level 5 in management. One nurse had completed their nurse prescriber training. All training was recorded in an electronic record and monitored by the head of human resources. CareTech offered a management development programme through its national learning and development team. Aspiring managers could access coaching and specific training on managing staff.

Directors who had recently joined the organisation said they had received a comprehensive induction. This had involved meeting their teams, attending key meetings and meetings with other directors across the business.

Staff had access to additional training to support their roles. For example, an assistant psychologist had received additional training to enable them to move into a dedicated staff training role in 2024. Professional staff participated in continuing professional development programmes.

The provider recognised the achievements of staff. It held an annual awards ceremony to celebrate the successes of staff working across CareTech. The winner of the employee of the year award was invited to become a trustee of the CareTech Foundation for one year. This meant they could be involved in decisions about allocating grants that the foundation provided for causes related to social care, social care workers and people living in care.

Governance

The board of CareTech met every two months. Additionally, the chief executive and director of finance met to conduct a business review of each division of CareTech every month. Board compliance reports for CareTech were circulated ahead of meetings of the Care and Quality Governance Committee each quarter. The purpose of these meetings was to provide assurance to the board and to both mitigate and manage risks. The executive committee reviewing these reports comprised of the Chief Executive, the Group Director of Compliance and Regulation, the Chief Finance Officer and the Human Resources Director. Reports to these meetings were heavily

focused on statistics relating to ratings of CareTech services. There was no analysis of specific risks. However, none of these meetings were minuted. Therefore, there were no records to show how the board was aware of, and managing, risks and performance within services.

Coveberry staff reported that prior to the appointment of the group medical director, there was a minimal level of governance, all of which took place in isolation at each service. However, directors and hospital managers said there had been significant improvements in governance in the 12 months before this assessment, particularly at services that had been rated inadequate, although they recognised there was still more work to do.

In September 2022, the provider had introduced a clear structure and agendas for governance meetings at a divisional level. A clinical governance meeting for the specialist adult service division (which included Coveberry) was held once a month. This meeting was chaired by the head of governance. The meetings were structured around the CQC domains of safe, effective, caring, responsive and well-led. Discussions included a review of incidents, data on safeguarding, data on complaints, information about training and information on staffing.

There were three sub-committees that reported to the clinical governance meeting. They covered quality, the Mental Health Act and the medicines safety. All meetings at an operational level followed standard agendas and the use of data to discuss trends in quality of care. The Care, Quality and Governance Sub-Committee for the division took place each month. It was chaired by the group medical director and attended by the head of governance, along with operations directors, managers from CareTech's compliance and regulation team, and performance directors. The minutes of these meetings were thorough and included data on physical interventions, mandatory training compliance, medicine errors and complaints. The minutes of these meetings included an action log to monitor the completion of tasks agreed at the meeting. After these meetings, a document setting out '5 Key Messages' was sent to registered managers, members of multidisciplinary teams and clinical team leads. For example, the '5 Key Messages' document in September 2023 provided information about medicines safety, a campaign to highlight and address overmedication of people with learning disabilities, changes to specialist services, CQC guidance and quality improvement training.

The Medicines Safety Group was set up in November 2022 and had met 4 times in 2023. The group was chaired by the group medical director. It was attended by the head of governance, the operations directors, compliance and regulation managers and managers from the services. The meetings were thoroughly minuted. The group reviewed reports on medicines errors and audit actions, feedback from recent CQC inspections and reports from pharmacists. The minutes of the meetings were accompanied by an action tracker.

The services had introduced an audit process that incorporated quality components that were used as key performance indicators. The key performance indicators included information on incidents, staffing data, targets for mandatory training and targets for supervision and appraisals. Reports of key performance indicators were produced monthly and reviewed by the senior leadership team. Staff said that operational directors had been very supportive in making these improvements. Daily huddles took place at each service to share information about risks with all staff. One of the hospitals had an enhanced level of governance monitoring to reflect the risks and complexity of its patients. At this hospital, staff met each week to analyse incidents and feedback from staff and patients.

Governance information did not always flow across the organisation. Hospital managers submitted notifications and reports of investigations into serious incidents to the group director of compliance

and quality. However, they did not receive any information in return and were not informed of decision making above the divisional level. This meant that it was difficult for them to understand why they were submitting the information or what it was then used for.

The chief executive, director of compliance and executive director for specialist services met once a week. However, meetings at a very senior level were not systematically recorded. This meant that decision making could be opaque. It could be difficult to identify when specific decisions had been made and who made them. For example, some directors did not know who had made the decision close a hospital at short notice, or when that decision had been made.

Coveberry had arrangements in place to monitor the quality of its own services. Staff told us about governance initiatives they were involved in. For example, staff told us about reflective practice sessions, daily patient huddles and the quality audit framework.

Governance arrangements were in place to ensure that the provider discharged its specific powers and duties according to the provisions of the Mental Health Act 1983, Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Mental Health Act and Mental Capacity Act Committee met every three months. The committee was chaired by the group medical director. It was attended by the operations director, group safeguarding lead, compliance and regulation managers, the Mental Health Act lead administrator and managers from the services. These meetings were thoroughly minuted. At the meeting in September 2023, staff discussed assessments of capacity and consent, tribunal reports, recent incidents involving patients on leave and a review of incidents relating to the Mental Health Act in the last six months.

The provider offered Mental Health Act training to staff. In September 2023, 80% of staff had completed mandatory training on the Mental Health Act.

In services where patients are detained under the Mental Health Act, the Care Quality Commission had conducted regular Mental Health Act review visits to ensure compliance with the Code of Practice 2015. There had been four Mental Health Act monitoring reports and one thematic seclusion review that took place between September 2021 and May 2023. Within these reports, there were 27 concerns about the implementation of the Code of Practice. Of these, 13 related to empowerment and involvement, 10 related to purpose and effectiveness and 2 concerned least restrictive practice. Following each visit, the provider submitted an action plan setting out how they would address the concerns that had been raised. During these visits, 6 patients had raised concerns with Mental Health Act reviewers. These related to physical health monitoring, engagement with family members, discharge planning and a request to have more time with staff. Outcomes and feedback from these Mental Health Act review visit reports were presented through the governance committees.

Oversight of the Mental Capacity Act took place through the Mental Health Act and Mental Capacity Act sub-committee. During the meeting in June 2023, there was discussion relating to how the services ensure they are up to date with applications and renewals of deprivation of liberty safeguards.

The Mental Health Units (Use of Force) Act 2018 was commenced on 31st March 2022. Statutory guidance sets out the requirements for providers to comply with the Act. Coveberry had allocated a responsible person for the Act, in line with guidance. It had a policy outlining how the provider would comply with the Act, including how it ensures that staff receive accredited training on physical interventions.

The provider understood and met all relevant legal requirements, including Care Quality Commission registration requirements, safety and public health related obligations and the submission or notifications and other required information. In the 3 years from December 2020 to November 2023, the four current hospital services had submitted 427 statutory notifications to the CQC. Of these, 313 concerned actual or alleged abuse. A further 59 related to incidents involving the police. Twenty-nine involved serious injuries to patients. Managers had circulated guidance on submitting notifications to the CQC.

An information governance group had been introduced as part of the provider’s governance framework. This group was chaired by the senior information risk owner.

Coveberry had a complaints policy which outlined the process and timelines for staff to follow in acknowledging and responding to complaints. Between 1 February and 30 September 2023, the adults and specialist services division of CareTech had received 75 complaints. Whilst the data on the number of complaints was reviewed in divisional clinical governance meetings, there was no discussion about the nature of complaints. This meant the service was unable to monitor and trends or themes from complaints.

We reviewed five complaints. The quality of investigations and responses were varied. For two complaints there were thorough investigations involving interviews with staff, reviews of footage from closed-circuit televisions and action plans for staff training and local resolution. On two complaints, the investigations were less thorough, but reasonably proportionate to the nature of the complaint. In most cases, staff supported the complainant by meeting them to discuss the complaint. However, for two complaints, no formal record was available.

Management of risk, issues and performance

Coveberry struggled to address the risks presented by the hospitals it acquired in December 2020. At the time of the acquisition, the provider had been seeking to broaden the care pathway for its patients into hospital services. The ambition was to create a model of care in which patients could move from hospitals into step-down accommodation within Coveberry services to ensure the continuity of care. In less than a year after the acquisition, one of the hospitals had been closed by the Care Quality Commission (CQC). A further two hospitals were rated inadequate and placed in special measures in January 2022. Some directors noted that it had been difficult to conduct thorough due diligence due to Covid restrictions at the time. The provider had taken steps to address these challenges by appointing a group medical director and a head of governance. However, this did not take place until 18 months after the acquisition, during which time patients had been exposed to high levels of risk of abuse.

As part of its plans to reconfigure its services, Coveberry was closing two of its hospital sites. The provider identified three key components of this strategy that all entailed operational and commercial risk. These were the transfer of patients to new services, retaining sufficient complement of staff during a time of uncertainty and creating a new model of service delivery that was commercially viable. In order to address these risks, the provider had created a team including the medical director, operations director and hospital director to oversee the discharge pathways for patients who would need to move to other hospitals before the new model of care was introduced. The provider was considering options for retaining staff, including schemes for redeployment within CareTech and guaranteeing employment beyond the introduction of the new services. The provider was also meeting with stakeholders to develop a clearer understanding of

commissioning priorities. The closure of one service had been announced six months ahead of the closure date. The provider had a clearly structured plan for the decommissioning of this service. Commissioners said they were assured that the closure process, including the transfer of patients to other sites, was being managed well. However, at another hospital, staff and patients had only been given one month's notice of the hospital closure.

The provider had systems to identify and escalate risk. Staff explained that they carried out risk assessments for patients and service users. These included assessments of specific risks, such as choking, falls and moving and handling. Care plans, personal behaviour support plans and risk assessments were updated after incidents. At some services, staff assigned patients a risk rating on a red, amber and green scale. Staff discussed risk incidents at handover meetings at the start of each shift. Incidents were then discussed in more detail at ward rounds and monthly incident review meetings.

The provider had an electronic system for staff to report safety incidents. This had been introduced at all sites, except for one. Staff were familiar with this system and knew how to use it. The use of the electronic system ensured that details of all incidents were automatically sent to the operations director. One senior manager said they sought to encourage staff to report errors, near misses or incidents. However, they recognised that increases in reported incidents could impact negatively on key performance indicators. This meant that staff may be reluctant to report less serious incidents.

Risk registers were available at a site level and divisional level. The divisional risk register contained 10 risks. The register had a description of each risk, statement of the impact of the risk and details of mitigation that was in place. A score was assigned to each risk based on its likelihood and severity. The highest scoring risks related to the recruitment and retention of staff, access to training, concerns about facilities and reduced occupancy. However, updates to the register appeared infrequent. Eight of the 10 risks had been identified in May 2022. The other two had been identified in July 2022 and February 2023. Although the risk register said that risks were reviewed monthly, we found no evidence to support this. Minutes of governance meetings did not include any specific reference to the risks on the register. During interviews, none of the directors referred to ways of addressing these risks in discussions about the strategic development of the services. However, they did talk about other risks, such as the high use of agency staff.

The service managed financial risks. At each service, the registered manager received a clear statement of income and expenditure. These managers were involved in costing the services through an annual process for agreeing budgets. The services had measures in place to prevent fraud such as auditing petty cash and setting limits on the authorisation of expenditure. Low occupancy rates, high expenditure on agency staff and the time taken to repurpose existing assets with long-term leases were creating a financial burden. However, the service was able to offset financial risks at Coveberry against the wider CareTech portfolio, meaning that it remained well-capitalised.

Senior managers had oversight of serious incidents but there was little evidence to show they had read the incidents reports or taken any action to prevent such an incident happening again. Between 1 November 2022 and 31 October 2023, staff had recorded 23 serious incidents on the electronic incident record. Staff completed records, including details of the circumstances surrounding the incident, the action taken, and lessons learned. Service managers investigated incidents thoroughly and provided reports of these investigations in a standard format. Serious

incidents and incidents requiring a statutory notification to the CQC were sent to the medical director, head of governance and the director of compliance and quality. Details of serious incidents were circulated to NHS England. However, there was no forum for the discussion of incidents at an executive level. Staff told us that reports of investigations into serious incidents were ‘signed off’ by the director of compliance and quality, but there was no evidence of this on the records, nor evidence to indicate that executive leaders had any oversight of incidents.

The provider had systems for identifying improvements that needed to be made following incidents. Each incident report provided details of immediate action staff had taken to address the risks created by the incident and ensure patients’ safety. There were some examples of staff changing processes to prevent incidents happening again. For example, staff changed the arrangements for allowing patients to leave the wards after a patient had taken considerably more leave than had been authorised.

The provider did not always ensure that services fulfilled their duty of candour towards people using their services when things when wrong. There was some evidence of staff telling patients that errors had occurred and some cases of staff apologising to patients. Following two incidents, the service provided a comprehensive letter to the patients that was consistent with their duties in relation to the duty of candour. However, there was an incident that involved a patient experiencing moderate harm due to a medication error and another incident involving a patient being improperly detained under the Mental Health Act for an extended period. The provider did not provide an account of the full facts to the patients or provide a written apology to either patient.

Systems had been put in place to identify and learn from unexpected deaths. In June 2023, the group medical director had introduced a policy and procedure for learning from deaths. Staff had received training in using a structured judgement mortality review tool. There had been just one death in the services over the last year. Details of this were recorded on the electronic incident record and circulated to senior staff. The record noted that staff had managed the situation well. A statutory notification was sent to the Care Quality Commission.

The provider was at the early stages of monitoring its use of restrictive practices and introducing a programme of work to reduce this. The monitoring of physical interventions had been introduced to the standard agenda for divisional clinical governance meetings in October 2023. The notes of meetings included a graph showing there had been around 4 incidents recorded each week that involved physical interventions. However, there were no details about where the incidents occurred, or whether they involved restraint, seclusion, or rapid tranquilisation.

The provider had good oversight of safeguarding concerns and had systems to ensure this was carried out to an appropriate standard. Staff said they received safeguarding training. Staff knew who the safeguarding lead was at their service and were familiar with arrangements for contacting the local authority. They also had access to the safeguarding policy. We reviewed six records in detail. These records showed that staff had appropriately raised safeguarding concerns, staff supported patients after incidents, de-briefing sessions were held and learning from safeguarding incidents was recorded. There was clear evidence that notifications had been sent to the Care Quality Commission and the local authority. However, directors felt there was scope for improvement, potentially through more communication with local safeguarding boards and producing more comprehensive briefings for staff.

The provider had a dedicated safeguarding lead. Their role was to have an oversight of safeguarding and develop a safeguarding strategy. They monitored compliance with mandatory training on safeguarding. This was provided at three levels. Level 1 training was an online course, level 2 involved the completion of a workbook and level 3 involved face-to-face training. Compliance with mandatory safeguarding training was reviewed in divisional governance meetings in the context of compliance with the overall mandatory training programme.

Safeguarding incidents were reported through the provider's incident reporting system and overseen by the managers. Reports of governance meetings contained data on the number of safeguarding incidents, and there was some analysis of themes and trends. For example, during the divisional meeting in August, managers discussed specific medication errors at one service and an allegation of bullying at another service. However, at one hospital there was an incident involving threatening behaviour, use of a sharp implement, destruction of the environment and the involvement of the police. The minutes of the following divisional governance meetings stated there was an increase in incidents at the hospital. There was no discussion of themes or analysis. This meant that managers at the governance meeting may not be aware of the severity of incidents. A senior manager felt that too much emphasis was placed on reviewing the number of incidents rather than analysing trends. They also felt that viewing increases in safeguarding reports negatively could discourage people from reporting.

The provider had assigned a compliance advisor within the Compliance and Regulation team as the lead for patients' physical health. Their role included responsibility for the oversight of infection prevention and control. Infection, prevention and control was discussed in divisional governance meetings and sub-committees. For example, during the divisional governance meeting in August 2023, managers discussed the possible increase in hand hygiene measures and the use of personal protective equipment due to an increase in cases of COVID. Managers also discussed infection, prevention and control in relation to the needs of a specific patient.

The provider had systems for the oversight and management of medicines. All nurses were mandated to complete training in medicines management. The group medical director was the controlled drugs authorised officer for each service. The services were supported by external pharmacies that provided their medicines. Managers circulated safety alerts from the Medicines and Healthcare products Regulatory Agency to all staff.

There was some awareness of the national project for stopping over medication of people with a learning disability, autism, or both (STOMP). The aims of this programme were discussed in the Care, Quality and Governance Sub-Committee Meeting for Adults and Specialist services in September 2023. Information was distributed to staff through the '5 Key Messages' document.

The provider had systems in place to authorise capital expenditure. Senior managers developed plans for their services and submitted a business case for any investment required. The business case would then be reviewed and authorised by the Chief Executive and Head of Finance. The service aimed to respond promptly to any requests for expenditure needed to maintain patients' safety.

Information Management

The provider had comprehensive systems of information technology. This enabled services to record their work and produce data about their performance. Most staff said they were provided with good quality equipment that was regularly updated, although some staff said that computers were slow, and this made them difficult to use.

An incident reporting system had been introduced across Coveberry services. This enabled some service user data to be extracted with relative ease. Governance meetings did have access to a range of data. The collection and analysis of this was not time consuming. A hospital director said there was an aspiration to introduce live dashboards for performance indicators and that the organization was working towards this.

The provider collected the data and information needed to have sufficient oversight of the service. This included key data about staffing and occupancy. The services also completed a monthly quality assurance framework. The provider used one financial system across all its services. This meant that staff could provide consistent information about all aspects of financial management.

All staff did not always have access to help and support with matters relating to information technology. Staff said it was difficult to access the helpdesk for information technology (IT). At one service, staff had been left without access to computers for five days. The provider did not have systems to place to monitor the response times to requests for IT support.

The provider had an internet portal that staff could use to access policies.

The provider had comprehensive systems to ensure good standards of data protection. At the time of this assessment, the provider had a draft policy and procedure in place for information governance. This was approved shortly after our assessment. The policy included a statement of purpose and the procedure for managing information governance.

An information governance group for CareTech met each quarter. This group was chaired by the Senior Information Risk Owner. Staff had recorded 2 information governance breaches at Coveberry services in November 2023. In both cases, an investigation had taken place. Staff and managers had discussed how to prevent such an incident happening again. For example, after one incident, all staff were reminded to collect documents from printers within 15 minutes.

Engagement

The provider had not fully engaged with staff and people using their services in decisions to close its hospital sites. Staff were very surprised by the recent decision to close a hospital. They said that they had worked hard to make considerable improvements to the service over 9 months and that they had not been involved in the decision to close.

The provider was engaged in some co-production with its patients and service users. CareTech had stated that involving patients and service users was a strategic priority for 2023/24. The marketing director worked across CareTech to engage with, and understand, the views of people using services and their families. They spoke with pride about the annual staff awards and the national arts and crafts awards people using CareTech services. At Coveberry services, staff told us about initiatives to encourage patients and service users to become ‘champions’ for specific areas of quality within the service. For example, one service had a champion for health and safety and another for the environment.

Coveberry had some arrangements in place to gather the views of people who used their services to shape and improve them. Coveberry services held residents' forums every two weeks. Staff produce 'You said, We did' displays to show how they had responded to comments and suggestions from patients and service users. Staff held debriefing sessions with patients after incidents. However, there were no formal systems in place to engage patients in strategic decisions and imminent changes that were taking place at the services. The services did not have any systems in place to seek comprehensive feedback from people using services and their families. People using services did not attend governance meetings at director level. There was limited evidence of any co-production initiatives.

Learning, continuous improvement and innovation

The provider had set out its ambitions for the introduction of quality improvement initiatives at a divisional level in a document for staff in 2022. All four hospitals had registered with quality networks facilitated through the Royal College of Psychiatrists. All Hallows was applying for accreditation as an approved care provider within a programme run by a national brain injury association. A programme of quality improvement work was being led by the group medical director who had experience in using quality improvement methodology. Training in quality improvement was being arranged for all registered managers. The first session took place October 2023. Information about QI initiatives was distributed to staff in the '5 Key Messages' document for September 2023. However, this remained in the early stages of development and no specific quality initiatives had been set up.