Cygnet Health Care Limited

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Reactive Provider Well Led Review	Cygnet Hospital Beckton	1-130471820
	Cygnet Hospital Bierley	1-130486669
	Cygnet Hospital Blackheath	1-130486688
	Cygnet Hospital Coventry	1-2984426383
	Cygnet Hospital Derby	1-130486705
	Cygnet Hospital Ealing	1-130486723
	Cygnet Hospital Godden Green	1-130486742
	Cygnet Hospital Harrogate	1-130486763
	Cygnet Hospital Harrow	1-130486784
	Cygnet Hospital Kewstoke	1-130486804
	Cygnet Hospital Maidstone	1-5805833788
	Cygnet Hospital Stevenage	1-130486821
	Cygnet Hospital Taunton	1-1993210561
	Cygnet Hospital Wyke	1-130486838
	Cygnet Lodge Brighouse	1-130486855
	Cygnet Lodge Kenton	1-130486890
	Cygnet Lodge Lewisham	1-130486872
	Tabley House	1-130486941

Summary of findings

	Tupwood Gate	1-130486958
	Coulby Lodge	1-2652777434
	Cygnet Bostall House	1-519868002
	Cygnet Cedar Vale	1-894198541
	Cygnet Chesterholme	1-894198689
	Cygnet Newbus Grange	1-894282280
	Cygnet Thors Park	1-519903445
	Cygnet Wast Hills	1-894095716
	Cygnet Whorlton Hall	1-894121431
	Cygnet Yew Trees	1-519903751
	Ducks Halt	1-519868553
	Hollyhurst	1-894282013
	Hope House	1-894166807
	Oaklands	1-894282487
	Old Leigh House	1-519903124
	Redlands Residential Care Home	1-894136857
	River View Residential Home	1-894137543
	Supported Living Staffordshire	1-4899173407
	The Orchards	1-519903260
	Thornfield Grange	1-894198181
	Toller Road	1-894167334
	Willow House	1-894197894
	Cygnet Appletree	1-463761234
	Cygnet Aspen Clinic	1-133291808
	Cygnet Aspen House	1-2286923346
	Cygnet Brunel	1-4281002813
	Cygnet Churchill	1-207202943
	Cygnet Community Services East Midlands	1-1389897500

Summary of findings

	Cygnet Community Services West Midlands	1-2542305795
	Cygnet Fountains	1-133291888
	Cygnet Heathers	1-1942493938
	Cygnet Oaks	1-271891457
	Cygnet Raglan House	1-185278360
	Cygnet Sedgley House and Cygnet Sedgley Lodge	1-133291660
	Cygnet Sherwood House	1-133291872
	Cygnet Sherwood Lodge	1-507438355
	Cygnet St Augustine's	1-133291904
	Cygnet St. Williams	1-6381248246
	Cygnet Storthfield House	1-133291824
	Cygnet Victoria House	1-133291856
	Amberwood Lodge	1-2957811221
	Broughton House and College	1-132671148
	Broughton House and College	1-132671164
	Broughton Lodge	1-2131341102
	Devon Lodge	1-2957811268
	Elston House	1-2092650896
	Nightingale	1-2957811325
	Oakhurst Lodge	1-2957811372
	Squirrels	1-2957811428
	Cygnet Acer Clinic	1-2006236460
	Cygnet Alders Clinic	1-2003449876
	Cygnet Hospital Clifton	1-186717868
	Cygnet Hospital Colchester	1-118514298
	Beeches	1-334339672
	Birches	1-871549470
	Chaseways	1-4378110026

Summary of findings

	Conifers	1-1889826136
	Cygnet Cedars	1-401158098
	Cygnet Elms	1-401158390
	Cygnet Grange	1-498863690
	Cygnet Lodge	1-314147095
	Cygnet Manor	1-169587897
	Cygnet Views	1-2259383961
	Eleni House	1-2259425731
	Fairways	1-2574723209
	Farm Lodge	1-4385513180
	Gables	1-2259433481
	Gledholt	1-2576938612
	Marion House	1-5134935368
	Pines	1-914040418
	Shear Meadow	1-3991672193
	The Fields	1-2259216171
	Walkern Lodge	1-4053879325
	Cygnet Hospital Bury	1-168579956
	Cygnet Hospital Sheffield	1-222659082
	Cygnet Hospital Woking	1-131834861
	Cygnet Lodge Woking	1-1345201412
	Woodleigh Care	1-527967595
	Beckly House	1-127478112
	Hawkstone House	1-127478084
	Langdale House	1-127478140
	Oxley Woodhouse	1-127478126
	The Outwood	1-2837729886
	Thornfield House	1-127478098
	Dene Brook	1-796891867

Summary of findings

	Longfield House	1-530762441
	Lowry House	1-3028885129
	Woodrow House	1-5879144469
	Norcott House	1-352114449
	Norcott Lodge	1-1815792421

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The Care Quality Commission (CQC) carried out a reactive provider well-led assessment of Cygnet Health Care Limited between the 2 July 2019 and 2 August 2019, with a short notice announced assessment at the provider's offices on 2, 3 and 12 July 2019.

Cygnet Health Care Limited provides mental health and learning disability services from over 113 locations across England, Wales and Scotland.

During our assessment we:

- interviewed the leadership team and reviewed evidence at the Cygnet Health Care Limited offices at 4 Millbank, London, SW1P 3JQ
- carried out focus groups with the registered managers from a range of services delivered by Cygnet Health Care
- carried out a focus group with the quality assurance managers employed by the provider.

The CQC regulates health and social care providers in England so this assessment did not consider evidence from locations in Wales or Scotland.

CQC has not published a rating as part of this provider well led assessment.

Overall Summary of our findings:

- Governance systems and processes were not effective in maintaining sustainable and high-quality care. The systems and processes in place had not prevented or identified significant issues in locations which have resulted in breaches of regulation and hospitals being placed into special measures due to inadequate ratings.
- Not all senior leaders could provide a clear explanation of how governance systems and processes were implemented in the organisation. Data provided to the board lacked interpretation or analysis to support the board in highlighting concerns and considering appropriate action.
- The integration of services acquired by Cygnet Health Care had not been completed. Some policies and procedures had three versions in use - Cygnet Health Care, Cambian Adult Services and Danshell Group, all now branded as Cygnet Health Care.

  Performance and quality reporting from the Danshell Group locations did not include some measures used by Cygnet Health Care to monitor the quality of services. Different information systems were in use across the organisation for human resources, incident reporting and patient records.
- There was not a clear escalation process for risks identified at location or regional level to the corporate risk register. The corporate risk register did not rate the severity of risks and detailed only location related risks.
- Care and treatment did not always include best practice. Training for intermediate life support was not provided to all relevant staff across services where physical intervention or rapid tranquilisation was used. There was a high use of physical restraint and seclusion across services compared to similar services in other mental health providers.
- Not all the required checks had been carried out to ensure that directors and members of the executive board were “fit and proper”.
- Not all members of the executive team could describe Cygnet Health Care’s current strategy as a provider of health and social care services. There was no quality strategy in place and no framework for continuous quality improvement across the organisation.
- The external scrutiny of the executive team’s decisions in the absence of non-executive directors was limited.
- There was limited capacity to deliver safeguarding supervision to all staff involved in safeguarding children or adults. Further training was being provided to increase the number of staff able to provide safeguarding supervision.

Summary of findings

- A freedom to speak up guardian had not been appointed, although a raising concerns policy and external whistleblowing telephone line were in place to support staff to raise concerns.

However:

- There was a stable senior executive and leadership team in place with a range of skills, who worked together to support the delivery of care.
- Cygnet Health Care's vision and values supported a person-centred approach to providing services. There was a strong emphasis on understanding the patient's experience of the service they received and how it could be improved. Experts by experience worked across services to provide advice and support to improve patient experience.
- Senior leaders took steps to improve the quality of patient care once concerns were identified.
- Senior leaders were known by staff at all levels, approachable and had regular contact with staff across the organisation.
- A culture of openness was encouraged by leaders and embedded within policy. Most staff knew what should be reported and felt able to do so.
- Most services across health and social care have been inspected by the CQC and rated as good and some rated as outstanding.

Summary of findings

Our inspection team

The team included a deputy chief inspector, two heads of inspection, two inspectors, a policy manager and three specialist advisors. Specialist advisors are experts in their field who we do not employ directly.

The inspection team was selected to include experience from both the NHS and independent health sectors and CQC inspection staff from mental health and adult social care teams.

Why we carried out this inspection

CQC inspected 47 of Cygnet Health Care's registered locations in England between May 2018 and April 2019 as part of CQC's planned inspection programme. Whilst the inspections identified a number of positive factors they also identified some concerns linked to the provider's leadership and governance arrangements. Further details are below:

- Significant concerns were identified regarding the safety and culture of Cygnet Whorlton Hall following the BBC Panorama programme,
- During the inspection of Cygnet Health Care locations, 15 locations were found to have concerns, including breaches of regulation which linked to Cygnet Health Care's policies, procedures or governance arrangements.
- There had been increase in enforcement activity being carried out by the CQC in Cygnet Health Care's hospitals.

This led to a reactive provider well-led assessment of Cygnet Health Care Limited at their UK administrative offices in 4 Millbank, London, SW1P 3JQ.

Information about the provider

Cygnet Health Care Limited provides services to children and adults across England, Scotland and Wales. It provides the following types of service:

- Secure mental health
- Psychiatric intensive care units
- Acute admission wards for adults
- Older people's services
- Rehabilitation and recovery
- Personality disorder
- Child and adolescent mental health services
- Eating disorder
- Learning disabilities
- Mental health services for deaf people
- Autistic spectrum disorder
- Neuro psychiatry

Cygnet Health Care has 15 providers registered with the CQC and has a total of 113 registered locations in England, including 58 independent health locations and 55 social care locations. The largest proportion of registered locations are in the central region (45 locations) and the north region (44 locations). There are 24 locations registered in London and the south of England. The findings of this responsive well led review are being reported under Cygnet Health Care Limited but includes information from across all 15 providers and 113 registered locations. There is a single executive board and senior leadership team for all the 15 registered providers.

Cygnet Health Care provides approximately 620 beds across their social care services and approximately 1881 beds across their health care services.

Cygnet Health Care is an independent provider founded in 1988. Since September 2014 it has been a wholly owned subsidiary of Universal Health Services Inc. (a United States of America based health care provider).

Summary of findings

Cygnet Health Care has developed significantly since 1988 with several acquisitions taking place:

- Alpha Hospitals Group in August 2015.
- Cambian Adult Services (CAS) from Cambian Group Plc in December 2016.
- Danshell Group in August 2018.

As of June 2019, 107 (95%) locations had received a rated inspection; seven (7%) locations were rated outstanding, 86 (80%) locations were rated good, 14 (13%) locations were rated as requires improvement and 1 location was rated inadequate.

There was no regional variation in the ratings of adult social care services, three services were unrated, three services required improvement, 40 services were rated good and one service rated outstanding.

Health care services in the North of England had the most locations requiring improvement with half of rated services (eight of sixteen) rated as requires improvement, the remaining services were rated good with one service unrated.

Health care services in the central region of England were mostly rated good (17 services) or outstanding (five services). However, one service was rated inadequate and two services required improvement.

As of April 2019, Cygnet Health Care had:

- 22 locations with a current breach of regulation.
- One location in special measures.
- There were two published enforcement actions in the 12 months up to April 2019.Another 12 enforcement actions were in progress or pending an outcome.

At the time of the reactive well led review a number of Cygnet Health Care's services were being inspected or subject to the early stages of enforcement action with two services rated as inadequate. Prior to publication of this report the following nine services had been rated as inadequate or been placed in special measures:

- Cygnet Whorlton Hall.
- Cygnet Newbus Grange.
- Cygnet Chesterholme.
- Cygnet Hospital Colchester.
- Cygnet Thors Park.
- Cygnet Hospital Ealing.
- Cygnet Hospital Wyke.
- Cygnet Hospital Coventry.
- Cygnet Acer Clinic.

Cygnet Health Care Limited's financial statement filed in September 2018 showed that Cygnet Health Care Limited had an income of around £334 million during 2017 with an operating profit of around £40 million. Cygnet Health Care Limited employs more than 8800 staff. The majority of care provided by Cygnet Health Care is funded by the NHS.

Areas for improvement

Action the provider MUST take to improve

Cygnet Health Care Limited **MUST**:

- Must ensure that effective governance systems and processes are embedded across all services to support the delivery of sustainable and high-quality care. (Regulation 17: Good Governance)
- Must ensure that policies and procedures are consistent across all services to support staff in the delivery of care and treatment and to allow effective audit and assurance. (Regulation 17: Good Governance)
- Must ensure that clinical and corporate risks are identified and effectively managed at every level in the organisation including a clear risk escalation process. (Regulation 17: Good Governance)
- Must ensure that directors and executive team are fit and proper to hold their role by carrying out all checks required by fit and proper persons regulations. (Regulation 5: Fit and Proper Persons Employed)
- Must ensure that a freedom to speak up guardian is appointed in services commissioned by the NHS. (Regulation 17: Good Governance)

Summary of findings

Action the provider SHOULD take to improve

Cygnet Health Care Limited **SHOULD**:

- Should ensure that restrictive practices, including physical restraint, continue to be reviewed across all services and that action is taken to reduce the use of restrictive practices in line with current good practice guidance.
- Should ensure that safeguarding supervision is made available to all staff involved in safeguarding children and adults.
- Should review the arrangements for the independent challenge of the decisions made by the executive team.
- Should consider how Cygnet Health Care's strategy to achieve its vision is communicated effectively and understood by the leaders in the organisation.
- Should consider how data is used within the governance of the organisation including trend analysis and exception reporting to support early identification of emerging risks.
- Should consider the use of a quality improvement framework to support a culture of continuous improvement across all services.
- Should consider how actions from meetings within the governance framework can be more effectively monitored with clear timeframes for completion.
- Should continue to implement opportunities to benchmark quality and performance measures against providers of similar services in the independent sector or NHS.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our summary of this inspection can be found on page 9 of this report.

Our findings

Vision and strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

Cygnet's vision is "to empower you on your personal journey to make a positive difference. To be recognised as the preferred provider of outstanding quality care. To be the employer of choice in the health care sector."

Cygnet Health Care also had a clinical vision to "provide the highest quality care to our patients and residents at all times, regardless of where they are in their care pathway. We are committed to providing the highest quality and most effective care possible. We aim to achieve this through our highly trained and motivated staff working in partnership with patients, residents, their friends and relatives, our commissioners, and regulatory bodies."

The chief executive officer confirmed that Cygnet had developed a five-year strategy in 2016 which included the growth of social care provision. This strategy was reviewed due to the process surrounding the acquisition of Cambian Adult Services and Danshell Group.

Cygnet Health Care's current strategy 2017 focused on improved quality and sustainability of services whilst continuing to look at the organic growth of its mental health and learning disability services.

Cygnet Health Care's strategy in 2017 to achieve its priorities and deliver good quality care was to continue to grow both through mergers, acquisitions and organically develop the business through:

- further geographical coverage
- development and broadening of current service lines
- extension of service lines and care pathways
- reacting to the changing dynamics of our market and customers, in particular the NHS
- providing an environment and culture which promotes excellence in what we do and a fulfilling place for staff to pursue their careers.

Senior leaders were unable to give a clear explanation of Cygnet Health Care's strategy as a provider of health and social care services and referred to the vision and values of the organisation.

Culture

Senior leaders could describe the culture within the organisation and sought to promote a positive culture which included the attitudes, values and behaviour of staff and whether they felt positive about working in the organisation. Senior leaders described the importance of a caring and open culture where staff were respected, valued and motivated to provide high quality care.

Cygnet Health Care had developed values which were consistent with a person-centred culture. The values of integrity, trust, empower, respect and care to make a positive difference had been developed to support the vision of the organisation.

The values had been developed in collaboration with staff and were shared throughout the organisation including in the services that had been acquired by Cygnet Health Care. This was supported by the evidence from our inspection activity in locations and through the corporate documents and communications reviewed. Embedding the values in services was the responsibility of registered managers. Registered managers gave us examples of how values were embedded through training and the use of values champions who engage staff in discussing the values in their service.

The values are included in the induction of new staff joining the organisation and in the appraisal process. Registered managers stated that they also used values-based

questions when recruiting staff for their services. Following the acquisition of new services, workshops were being completed with staff who joined Cygnet Health Care to support staff to understand the values of the organisation.

The need to live the values throughout the organisation was reinforced within senior managers meetings and there was an expectation that values would be included in activities such as meetings, handovers and staff interviews.

Systems were in place to promote honesty and transparency following incidents. The need for openness and reporting of incidents was embedded within policy and discussed within a range of meetings. Leaders and registered managers talked about an open culture with a focus on quality of care and being able to raise issues without retribution. Evidence from inspections suggested that most staff felt able to be report incidents and raise concerns.

Registered managers were encouraged by the senior leadership team to be open and told us they were able to speak to anyone in the executive team. We were also given examples of senior leaders visiting services and speaking to staff teams regarding any concerns they may have.

However, there were themes identified from an analysis of 67 share your experience comments received by the CQC between May 2018 and November 2018 which raised concerns regarding culture. The content of the share your experience comments suggested that these were from Cygnet Health Care staff and included comments such as; managers were absent at important times, ignored the concerns of others and failed to provide enough staff; that in locations, there was active deception by hiding incidents and low staff numbers from the CQC and family members and concerns regarding the inexperience of staff and lack of training. Comments also suggested that concerns had been raised with Cygnet Health Care management before the CQC was contacted.

Duty of Candour was part of incident reporting and review processes. Duty of Candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain incidents.

Whistleblowing incidents were reported in the monthly corporate management board and the status of each whistleblowing investigation was monitored alongside any ongoing actions. Information presented to the corporate management board included current open whistleblowing incidents. Data was not presented to allow trends in whistleblowing to be identified by location over a period. In the 12 months up to April 2019 the CQC received 37 whistleblowing or staff concerns which were followed up with Cygnet Health Care.

Cygnet Health Care did not have an identified Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation. The NHS standard contract requires that providers appoint one or more Freedom to Speak Up Guardians. However, there were several routes for staff to raise concerns. These included a whistleblowing line which was commissioned from an external organisation, visits by the executive team and corporate teams to locations and direct access to the chief executive. Raising concerns (Whistleblowing) policies were in place, reviewed and next due to be reviewed in May 2020.

Current safeguarding policies were in place which clearly defined the roles and responsibilities of staff at all levels in relation to safeguarding both children and adults. The director of nursing was the executive lead for safeguarding and was supported by the corporate safeguarding professional, a social worker, who provided support to managers and front-line staff. A regional medical director was the named doctor for safeguarding. The number safeguarding referrals were reported to the quarterly regional governance meetings. Data was presented as the number of referrals in the current month, in comparison to the two previous months which provided only a limited range to identify trends by location.

Safeguarding supervision was not embedded within the organisation, supervision had been set up in April 2019 but there was a lack of safeguarding supervisors to support this across the organisation. This has been identified by Cygnet Health Care and further training was being provided to increase the number of safeguarding supervisors to six per region from the current four supervisors working across all services.

Safeguarding training was included in mandatory training across locations and the required level of training was

clearly indicated by staff role in the safeguarding policies. Safeguarding mandatory training completion across the organisation was 82% at April 2019 with 124 wards and services above 80% compliance.

Notifications

Cygnet Health Care are required to notify the CQC about certain changes, events and incidents that affect a service or the people who use them. These include the death of a person or unauthorised absence of a person detained under the Mental Health Act (17-1), the outcome of a deprivation of liberty application, abuse or allegations of abuse (18-2e), serious injury (18-2a,b) and incidents reported to the police (18-2f). The numbers of notifications are likely to be higher in areas where there are more services and it should be noted that notifications may be made prior to full investigation and outcomes being agreed.

During the period May 2018 to April 2019 the region with the highest number of notifications was the North with adult social care services making 647 notifications and health care services making 1328 notifications. Of these notifications the largest number was for the outcome of a deprivation of liberty application, abuse or allegations of abuse with 649 in health care services and 292 in adult social care services.

Incidents reported to the police were also included in the overall notifications. In health care services there was 468 incidents of police involvement and in adult social care there were 86 incidents of police involvement.

Across all regions health care settings had a higher number of notifications than social care services. Health care settings in the Central region had the highest number of notifications (707) related to the outcome of a deprivation of liberty application, abuse or allegations of abuse.

The number of notifications submitted by health care locations (IH) locations in the North and Central regions has been increasing since May 2018 (78% and 76% increase respectively), this increase is driven by a noticeable rise in the number of abuse notifications submitted by health care locations in both the Central and North regions.

Police incidents have also risen at health care locations in the North region.

The number of notifications submitted by adult social care (ASC) services has remained relatively stable over the period.

During our inspection activity the CQC identified that in some locations the required statutory notifications were not always made to the CQC. Failure to notify the commission is a criminal offence and where this was identified enforcement action was taken at those locations. The requirement to make statutory notifications had been discussed in the corporate board meeting to raise awareness in the organisation. In addition, reports without statutory notifications are reviewed and additional training has been provided to staff.

Cygnet Health Care carried out an employee engagement survey each year. The most recent staff engagement survey results (2019) was reported to the corporate management board in April 2019.

Participation in the survey was 70% of Cygnet Health Care and 64% of former Danshell Group staff (staff working in former Danshell Group locations were reported separately). It was also noted that the previous year's results were not directly comparable as staff from former Cambian Adult Services had been included for the first time in 2019.

The engagement survey asked staff for feedback on several areas including: their role, managers and workplace; responding to concerns; pay and benefits; health and wellbeing; communication and participation.

Staffing levels and sickness absence rates

Staffing levels were managed at location level by registered managers and with oversight by the executive team through the corporate management board. Board papers showed the numbers of starters and leavers, vacancy and turnover rates for each operational director. The five locations for both health care and social care were exception reported with the previous 12 months data.

Agency use, and temporary medical staffing costs were also reported to and monitored by the executive team. The percentage of nursing shifts covered by agency across Cygnet Health Care had increased from 20% in January 2018 to 34% in August 2018. Between August and December 2018 there had been a slight reduction to 33%.

Are services well-led?

The highest use of agency staff was in secure services. Agency use was also reported by location for the previous 12 months and the top five locations were reported by exception for the current month and year to date.

Human resource business partners met with managers every two months and this included a review of sickness absence levels. Sickness levels were reported weekly as a key performance indicator but we could not see evidence this was then reported to the corporate management board to allow it to be considered alongside other data for locations that may raise concerns. Cygnet Health Care reported for the period April 2017 to March 2018 their sickness rate was 4.3%.

Recruitment was co-ordinated by the human resources team. The recruitment and retention of staff was reviewed by the executive team and retention targets had been set with registered managers. Human resources business partners met with registered managers regularly to review staffing and staff retention. Managers in locations are responsible for appointing staff and ensuring pre-employment checks are in place prior to commencement of employment.

Staff development was considered as a factor in the recruitment and retention of staff. Cygnet Health Care had 70 apprentices in post at foundation degree level, a nurse associate programme had commenced with two nurse associates in post. It was also planned that a further 40 staff would be given the opportunity to train as registered nurses through a training programme linked with a distance learning university.

International recruitment was carried out through an international recruitment company. At the time of inspection Cygnet Health Care were looking to recruit over one hundred nurses from Zimbabwe and the Caribbean with twelve registered nurses ready to move to the United Kingdom as part of the programme.

Leadership capacity and capability to deliver high-quality, sustainable care

A leadership structure was in place and there was an experienced leadership team with a range of skills, knowledge and experience to support the delivery of good quality services.

The senior leadership of Cygnet Health Care consisted of the chief executive; chief operating officer; chief finance officer; chief information officer; human resources director; property director; director of nursing; chief commercial officer and a corporate governance director.

As Cygnet Health Care did not have an identified medical director for the group, each of the three regions in Cygnet Health Care's structure had a regional medical director who provided the medical leadership. One of these regional medical directors was identified as a member of the executive management team. However, we were told that all regional medical directors could attend the executive management team. The regional medical directors were all consultant psychiatrists.

The chief executive officer had decided to reinstate the role of group medical director and was looking to recruit to this role although there was no timescale for this.

Cygnet Health Care had an executive board in place and therefore did not have non-executive directors. There is no requirement for an independent health care provider to have non-executives on the board. As a result, there was limited scrutiny or challenge to the executive board's decision making by anyone not holding operational or management responsibilities within the company.

The chief executive officer was appointed in 2017 following Cygnet Health Care's acquisition of Cambian Adult Services. The chief executive officer had founded the Cambian Group in 2003 and led that organisation through its acquisition by Universal Health Inc. and subsequent integration into Cygnet Health Care. The chief executive officer had completed his medical training and worked across mental health services in the UK but did not practice as a doctor at the time of inspection.

The senior leadership team was stable with four members in post for more than ten years. The most recent appointment to the senior leadership team was the chief information officer who joined in 2019.

The director of nursing had joined Cygnet Health Care in 2018 as registered nurse for adults, with a range of experience including commissioning. The responsibility for the quality of service delivery was held by the managing directors within the organisation. Each location had a nominated individual and most locations had a registered manager in post.

Are services well-led?

Cygnet Health Care had a responsible officer in place. The responsible officer is a senior doctor who is responsible for the revalidation of doctors within an organisation and an annual report was submitted to the executive team.

The leadership team described positive working relationships and a shared aim to provide good quality services led by the chief executive officer.

Cygnet Health Care reviewed its operating structure in April 2018 moving to a model which separated the organisation into two divisions, health and social care. Each division had a divisional director who reported to the chief operating officer. The divisional directors were member of the executive team. The divisional directors were supported by regional operations directors and all hospitals had hospital directors. A head of education also reported to the health care division director and was responsible for education provision in child and adolescent mental health services.

Although Cygnet Health Care had moved to a health care and social care structure, locations which were registered as hospitals with the CQC (Whorlton Hall, Newbus Grange and Chesterholme) were located within the social care division. During interviews of the senior leadership team it was not clear to inspectors how this new structure linked to other operational structures, lines of reporting and the governance framework in the organisation.

The registered managers we spoke to within focus groups gave positive feedback regarding corporate communication and found immediate managers and senior leaders to be approachable. Registered managers gave examples of when senior leaders had visited their services and spent time speaking with staff.

There was a structure of operational and governance meetings at all levels within the health care and social care directorates and at a corporate level. Regional level meetings were led by operational directors and at corporate level, meetings were led by members of the executive team and attended by registered managers and operational directors.

Nursing staff and allied health professionals were represented within the leadership at a location level, regional and national level.

National leads were identified for specific functions with a network of local leads where this was required.

Cygnet Health Care did not have a leadership strategy. However, senior leaders recognised the importance of developing leadership in the organisation. Opportunities were available to support leaders to develop their skills, knowledge and experience within the organisation. Training was available for managers at all levels within the organisation; many people in leadership roles had a history of working for Cygnet Health Care or the companies it had acquired and being supported to develop their skills into more senior roles.

Succession planning was considered by the executive team and to support this Cygnet Health Care was developing and launching a “visionary leadership programme” in addition to its current management development programme.

The executive team had identified development time through away days.

The executive team understood their portfolios and had a knowledge of the current priorities and challenges to quality and sustainability. Actions identified by senior leaders were not always effective in addressing the challenges to quality and sustainability. Inspection and monitoring activity by the CQC found repeated issues across locations resulting in enforcement action being taken.

The executive team did not ensure all locations had a registered manager in post. As at June 2019 there were 8% of locations without a registered manager. Three of these locations had not had a registered manager for a period of 6 months.

Registered managers told us that the executive team were approachable and supportive. Staff at all levels including members of the executive team found the chief executive officer approachable and responsive to issues or concerns.

Fit and proper person review

Cygnet Health Care had a fit and proper person policy in place which outlined the procedure to ensure that directors of the company were fit and proper persons.

The required checks for directors or equivalent roles had not been fully completed. Documents provided by Cygnet Health Care did not evidence that references had been sought during recruitment or that insolvency and

bankruptcy searches had been carried out. There was evidence that directors' identity had been checked, disclosure and barring service checks had been carried out and that a health screening had been completed.

Responsibilities, roles and systems of accountability to support good governance and management

Governance structures and processes were not effective in supporting good quality and sustainable services. A matrix approach to governance was being adopted with several lines of reporting across the organisation giving opportunities for issues to be identified or raised. A clear line of accountability from the "ward to board" could not be established across all of Cygnet Health Care's locations.

Governance systems and processes had not prevented or identified significant issues within locations to allow effective intervention by the executive team. These included:

- Cygnet Hospital Wyke, in June 2019 we found that safe care was not being provided. Risk assessments were not fully completed and observations were not monitored or recorded. Managers did not act in a timely manner to make improvements.
- Cygnet Hospital Colchester, in May 2019 we found that governance systems did not adequately monitor, assess, manage and mitigate risks to patient safety. Managers had not responded to concerns in a timely manner and as a result risks to patients had increased.
- Cygnet Hospital Godden Green, in April 2019 we found that robust systems were not in place to allow staff to safely manage risks to young people.
- Cygnet Hospital Harrogate, in July 2018 we found that the hospital did not provide safe care. There was a high use of agency staff which impacted on safety and observation levels were not based on a completed risk assessment.
- At the time of the reactive well led review a number of Cygnet Health Care's services were being inspected or subject to the early stages of enforcement action with two being rated inadequate. Prior to publication of this report the following nine services had been rated as inadequate or been placed in special measures:

- Cygnet Whorlton Hall (now non-operational).
- Cygnet Newbus Grange.
- Cygnet Chesterholme (now non-operational).
- Cygnet Hospital Colchester.
- Cygnet Thors Park.
- Cygnet Hospital Ealing.
- Cygnet Hospital Wyke.
- Cygnet Hospital Coventry.
- Cygnet Acer Clinic.

Cygnet Health Care was taking action to make improvements at the locations identified. Cygnet Whorlton Hall and Cygnet Chesterholme were non-operational at the time of publication of this report following a decision by Cygnet Health Care, in collaboration with key stakeholders, to suspend the service pending extensive building improvement works.

Arrangements for independent external scrutiny of the executive teams' decisions was limited. There were systems in place which maintained a link between Cygnet Health Care and its parent company Universal Health Services Inc. with members of the executive team meeting with the chief executive officer / chair at least twice a year in a formal reporting board looking at quality and sustainability of delivery. Regular briefing calls including weekly calls between the chief executive officer, chief finance officer and human resources director were also in place with Universal Health Services Inc.

A further group which was not present on the governance structure or referenced by some members of the executive team during interview was the clinical oversight group. We were told this meeting was bi annual and attended by the executive team and chaired by an external legal advisor to Cygnet Health Care.

Following the well led review, Cygnet Health Care has made a decision to appoint an advisory board to complement the existing corporate governance framework.

A governance and operational management structure set out how operational and governance meetings related to each other. Below the executive level meetings there was a range of committees to support the governance process, including a drugs and therapeutics committee, a resuscitation committee and positive and safe committee.

Are services well-led?

The chief executive chaired some meetings at different levels within the structure, this resulted in an example where the chief executive effectively reported or escalated issues to himself as the chair of the next meeting in the structure.

The corporate management board, which met quarterly, oversaw the governance framework within Cygnet. A seven pillars of governance framework had recently been adopted across all locations in Cygnet Health Care. These were:

- Clinical effectiveness and research.
- Risk management.
- Patient and carer involvement.
- Staff management.
- Information management.
- Education and training.

The seven pillars of the framework were used to structure the agenda of regional governance meetings which were held quarterly. Location governance meetings were expected to take place every month.

Corporate management board meetings were supported by a data pack and an action plan was generated following each meeting.

The corporate management board data pack contained a balanced scorecard with a range of appropriate metrics. There was a lack of analysis or interpretation of the data pack for the board. For example, there was no evidence of analysis of issues in relation to safeguarding or whistleblowing. In relation to whistleblowing data was not presented by location and the timeframe of the data would not allow trends or themes to be identified.

The balanced scorecard for operations had several red rated issues. However, there was no evidence of a summary to board regarding these issues, no evidence of discussion at board in the minutes and no actions identified in the action plan.

Actions from meetings were not effectively managed. We saw an example of an action from January 2018 regarding checking data in relation to safeguarding which was still not completed in the April 2019 action log. While actions were named against individuals there was no date of when the action was logged and "asap" or "next meeting" was used frequently rather than specific time-frames. As a result, it was not clear how long actions had remained open on action logs.

There was evidence that the corporate management board had received reports from committees within the governance structure. In the board papers from April 2019 papers were submitted from the group safety committee which highlighted the unexpected death of a patient and included the root cause analysis, recommendation and action plan. Papers from the information governance committee were also submitted.

Local governance was still developing using the agreed framework following a governance review shared with managers in February 2019. The most recent changes to the governance systems and processes were made in July 2019. A clinical representative from each location was asked to attend a regional governance meeting. The agenda of the regional clinical governance meeting is based on the seven pillars of governance. A data pack is available to support the meeting and each location presents a report to the meeting.

The minutes we reviewed showed limited evidence of discussion or challenge regarding the data presented. Location reports to regional governance meeting were variable in quality, some reports contained a range of relevant information, others were partially completed with limited information.

In addition to the governance processes Cygnet had a number of quality assurance managers who carry out visits to locations to review the service being provided and produce a local action plan to address any areas for improvement. Cygnet Health Care had increased the number of quality assurance managers from 10 to 17 and recruited some staff into these posts with a regulatory background. Each location is planned to have two review visits each year. The quality assurance managers each have a defined portfolio of locations and report to the director of corporate governance. Quality assurance managers are also expected to attend regional governance meetings.

The chief executive had recently introduced a "mystery shopper". This individual member of staff was not identified to other staff in the organisation and reported directly to

the chief executive. The member of staff would work within locations and advise the chief executive of their findings to allow the executive team to make improvements where necessary.

Registered managers told us that they felt governance was effective with exception reports from local governance going to the regional governance meeting. They also were able to raise issues through the operational meetings route; this meant no issues could be "blocked" from being escalated. One registered manager told is that people were still getting used to the new governance process.

There was not a consistent process in place to escalate risks based on assessed severity of the risk by the regional team.

Audits were completed throughout Cygnet Health Care at both a national and a location level and aligned to CQC key lines of enquiry. There programme of audits undertaken across all sites was co-ordinated by a corporate team led by a head of quality. Audit results were reviewed at local, regional and national level as appropriate and action plans were developed where required to address issues.

Since the well led review Cygnet Health Care have commissioned a corporate governance review from an independent person.

Health and safety audits in locations were carried out by a company contracted by Cygnet Health Care and reported at location level.

Following the acquisition of Cambian Adult Services, Cygnet Health Care had planned to complete the integration of these services into Cygnet during the period April 2018 to July 2018.

The acquisition of Danshell was supported by an integration plan from the Competition and Markets Authority review in August 2018 in relation to the completion of the integration of Danshell Group and Cygnet Health Care in July 2019. This plan included a post-acquisition audit and portfolio review, 90 day and 180-day integration plan. The integration was planned to be completed by July 2019. The executive team confirmed that they had carried out due diligence checks on the Danshell Group prior to the acquisition. These checks had included a review of the ratings given by the CQC; visits by Cygnet Health Care to every Danshell Group location; governance and health and safety audit in each of the locations. These checks had not identified any significant concerns prior to the acquisition.

Following the intervention of the Competitions and Markets Authority intervention in relation to the acquisition of Danshell the integration plan was revised with completion expected by October 2019.

The integration of policies and procedures had not been completed following the acquisition of Cambian Adult Services or Danshell Group. Whilst the majority of polices had been reviewed for safety and rebranded as Cygnet Health Care, only approximately 20% had been integrated into a single Cygnet Health Care Policy. Many policies and procedures had three versions in current use depending on the location, the policies were stored in way which meant the relevant policy was available for staff at each location. There was no set target for the integration of all policies as the provider felt that the proper review and implementation of new policies was the priority rather than achieving this within a set timescale.

A consultant nurse was in post with responsibility for improving practice within services for people with a learning disability including the use of positive behaviour support.

Systems did not always identify that services followed best practice guidance and that new techniques, treatment/ procedures or models of care were introduced and communicated to services and embedded in a safe, effective, risk managed way.

Senior leaders had taken six months to start the implementation of additional essential training from the issue being identified by the organisation. In 2008, the National Patient Safety Agency (NPSA) issued a Rapid Response Report that identified that all providers of mental health or learning disability inpatient services where rapid tranquilisation, physical intervention, or seclusion may be used must have access to staff trained in immediate life support (ILS) and access to all equipment specified in NICE Guideline 25 (including AEDs).

We saw that in a clinical update at a hospital managers meeting in August 2018 it was recorded that ILS was rarely used but that it may become a requirement for staff to be trained in it. It was identified that additional training was required in services that had been acquired and a rota was

to be produced for ILS training. Training was commenced in January 2019 with exception of Danshell services where training commenced in August 2019. A risk assessment dated 25 June 2019 rated the absence of this training as high risk and confirmed that additional training would commence in August 2019.

A large number of people who Cygnet Health Care provide care to are detained under the Mental Health Act. Cygnet Health Care had systems and processes in place across locations which provided care and treatment to detained patients and support compliance with the Mental Health Act Code of Practice.

The CQC carries out monitoring visits to locations where patients are detained. We reviewed data from these visits carried out between May 2018 and April 2019. There was good compliance in relation to:

- evidence of physical health checks
- care plans showing evidence of discharge planning
- records showing the responsible clinician had recorded or assessed the patient's capacity at first treatment
- evidence of discussion with patients regarding rights
- approved mental health professional report being available
- availability of GP services for detained patients
- wards visited by an Independent mental health advocate.

A report is issued to the provider following the completion of a Mental Health Act monitoring visit and they are required to respond to concerns raised by issuing a provider action statement. An analysis of the concerns raised from 97 visits carried out in 2018 and 2019 found the following themes which the provider responded to:

- people were not always reminded of their rights
- people were not always aware they could complain to the CQC
- some blanket restrictions were found
- care plans were not always individualised, or recovery focused
- important documents were of poor quality, unclear, incomplete or missing
- access to activities and outdoor space
- staff shortages, particularly in the North and Central regions
- staff knowledge in relation to the Mental Health Act, particularly in North and Central regions
- practices which did not support privacy of patients, particularly in North and Central regions
- concerns regarding practice around the use of seclusion in North and Central regions.

The provider told us how they would address these issues with a provider action statement at each of the locations they were found. However, the same issues were identified in other locations which would suggest that learning from monitoring visits was not shared effectively across the organisation.

The use of physical restraint and seclusion was reported in the board data pack.

A restraint and violence reduction lead was in post, reporting to the head of learning and development. Cygnet Health Care has had a strategy in place for three years to reduce restrictive practice which is currently being revised due to organisational changes. The strategy includes training, workshops and focused work targeted at locations flagged as having high levels of restraint. Cygnet Health Care are members of the restraint reduction network.

A positive and safe board has been established at corporate level chaired by the director of nursing, with three regional boards and hospital boards. Regional leads and prevention and management of violence and aggression (PMVA) instructors attend the regional boards alongside experts by experience. The priority for instructors is to prevent issues that lead to incidents and work across sites to enhance learning. Locations that were part of the Danshell Group did not have local trainers. An advert had been placed for expressions of interest for 20 to 30 instructors to join the team and training was planned for August 2019. These new instructors will join the approximately 120 instructors across Cygnet Health Care.

Currently four models of restraint are in use across Cygnet Health Care. All conform to the necessary requirements and standards. All four models are based on the same principles, so this limited the risk of the different approaches.

Are services well-led?

Performance metrics relating to violence, aggression and restrictive practices are looked at every positive and safe board meeting.

The CQC's analysis of data submitted by Cygnet Health Care to the Mental Health Services Data Set for the period December 2017 to November 2018 showed a higher level of physical restraint and seclusion being used in their services compared to NHS providers of similar services.

It was also found that the number of patient assaults by other patients and self-harm were higher in Cygnet Health Care in comparison to NHS providers of similar services.

Whilst the comparison is made against wards of similar types between Cygnet and NHS providers, it does not take into account the level of need of individual patients admitted to these wards.

Medical Governance

Cygnet Health Care employed 190 doctors across its locations; 105 consultants and 85 speciality doctors.

There were four self-employed doctors who worked for Cygnet Health Care under practice and privileges. Cygnet Health Care was working to have all doctors employed and planned to have no self-employed doctors by the end of 2019.

A responsible officer was identified who had the oversight and governance of doctors employed by Cygnet Health Care. The responsible officer liaised with regional medical directors as required if there were concerns regarding doctors. In the year 2017 to 2018 the responsible officer reported that 103 of Cygnet Health Care's 106 doctors had received an appraisal which included a 360 feedback at least once every 5 years. Cygnet Health Care also made 20 positive recommendations for doctors' revalidation in the same period. During the year 2017 to 2018, six concerns had been raised about doctors' practice which resulted in remedial actions being taken.

Doctors were provided with opportunities to maintain their continuous professional development which included monthly development meetings which were available in regions for doctors to attend.

How appropriate and accurate information is processed, challenged and acted on

The executive board received a range of information on service quality and performance which were reported in data packs produced for use in meetings. There was evidence that information was challenged, and actions taken.

It had been noted that 41 locations had not shown as making any safeguarding referrals to local authorities during the period June to November 2018. This had been followed up with each location and in 31 of the locations referrals had been made but a recording issue had resulted in them not being reported in the safeguarding data. The corporate team now contact the locations to verify the data prior to inclusion whilst the recording issues are addressed.

There were clear key performance indicators for services which were reported to and monitored by senior leaders. These were reviewed at weekly operational management calls attended by the chief executive, chief operating officer, operational directors and human resources.

A lead was identified for the General data protection regulation (GDPR). There was a Caldicott guardian and senior information risk owner in place at executive level.

A central information team produced data for both internal and external use.

There were a number of information systems present within the organisation as a result of the acquisitions of Cambian Adult Services and Danshell Group. These included patient records, staff records and incident and risk reporting. As a result, some data had to be collected and produced manually, an example of this was staff at Danshell locations manually collecting data and adding it to a spreadsheet which introduced risk of errors. The different patient record system also resulted in some incomplete data being submitted to regional clinical governance meetings.

These different systems were being addressed with a new incident management system which included risk management being implemented this year, the roll out of a single staff record system which was being completed during our review and the introduction of a single clinical records system across all locations.

Are services well-led?

The Mental Health Services Data Set (MHSDS) is a patient level data set, which aims to provide robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with mental health services.

It is mandatory for all providers of NHS-funded specialist mental health services to submit data about people using these services to the MHSDS, including independent providers of NHS commissioned services.

NHS Digital publishes key information by provider each month and CQC also has access to a full extract of MHSDS data. Review of these sources indicates that:

Cygnet Health Care are submitting a range of data to MHSDS. However, on reviewing the published data submissions (as at March 2019) we found:

- The Danshell group were reporting a bare minimum of data limited only to the number of referrals and number of people in contact with services; there was no information in the national published MHSDS data for people with learning disability.
- The submission of data by Cygnet Health Care in relation to people with mental health problems is more comprehensive than the data relating to people with learning disability and children and young people.
- A number of locations which the CQC categorise as adult social care were submitting data to MHSDS.

These observations are further supported by the organisations' results on the Data Quality Maturity Index (DQMI). The DQMI is a quarterly publication intended to highlight the importance of data quality.

Based on the DQMI results for the period July to September 2018, Cygnet Health Care scored 87.8% for the DQMI based on their submissions to MHSDS, while Danshell Group results were far lower at 32.3%. By comparison, the average results for NHS providers of mental health services for this period was 99.8%.

Cygnet Health Care informed us that the data reporting issues from the former Danshell Group locations had been addressed in May 2019 and from July 2019 a single data submission from Cygnet Health Care was being made.

How the service continuously learns, improves and innovates to ensure sustainability

Systems were in place to identify complaints, serious incidents and unexpected deaths in the organisation. These were investigated, and learning identified. Systems were in place to allow the sharing of learning across the organisation, but these were not always effective.

All staff interviewed spoke about the importance of transparency when things went wrong. Registered managers gave examples of where learning and good practice was shared and sharing good practice was a standing agenda item on the regional and national clinical governance meetings.

There was evidence that Cygnet Health Care did not have the resources or methods to support leaders in driving improvement of services and systems on an ongoing basis. This included concerns such as:

- There was no quality improvement framework in use within the organisation.
- There was no quality strategy in the organisation. This is currently being developed by the director of nursing and is at the draft stage and was shared with the CQC.
- Following the acquisition of Cambian Adult Services in December 2016 and Danshell Group in August 2018, only 20% of policies had been integrated.
- Improvements and learning from incidents were not consistently implemented across all locations. Inspection activity found examples where the same issues identified in one location were also identified in another location.

We did not see evidence of participation in research projects during the well led review.

Cygnet Health Care joined the NHS Benchmarking Network in June 2019. This allows Cygnet Health Care to compare their performance on a range of measures against other providers. There was limited evidence at the time of inspection of benchmarking quality or performance measures against other similar providers.

Mortality and Unexpected deaths

A mortality review panel was established to review any deaths within Cygnet Health Care's services.

Based on statutory notifications, during the period May 2018 to April 2019 there were 3 deaths reported to CQC for patients detained under the Mental Health Act.

Are services well-led?

An analysis of information available on the mental health services data set for the period October 2017 to September 2018 showed that Cygnet Health Care's mortality rate (0.29 per 100 patients) was similar to that of NHS providers (0.31 per 100 patients).

Complaints

Cygnet Health Care had a current complaints policy in place which included information about their complaints management process and timeframes. Complaints were managed at location level, however, where complaints could not be resolved locally they would be escalated to the corporate team. An overview of complaints was not presented in the data pack submitted to the executive team.

The timescales identified were that a complainant should have an initial response within 48 hours and a final response within 20 days. If a complaint could not be resolved by Cygnet Health Care, the policy clearly outlined that complainants would be informed of their rights to seek external review via the ombudsman for NHS patients.

From the complaints reviewed during inspections at locations, we saw that most complaints were responded to appropriately, investigated and appropriate action taken.

Number of complaints made to the provider

The data submitted to the CQC as part of our inspection activity showed at total of 397 complaints for the period May 2018 to April 2019. There appeared to be no trends in relation to the number of complaints by region. An average of 48% of complaints were upheld with only one complaint being forwarded to the parliamentary health service ombudsman.

Themes identified from these complaints included:

- lost and stolen property
- attitudes of staff
- poor communication or lack of information
- concerns regarding medication
- quality of the environment.

The health care services in the North of England had the lowest number of complaints upheld at 23%, in contrast to the London health care services which upheld 53% of complaints.

Accreditations

Independent providers can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

Cygnet Health Care engaged are involved in the following accreditation schemes:

- Independent Neurorehabilitation Providers Alliance.
- The National Autistic Society, Autism Accreditation.
- Accreditation for working age inpatient mental health services (AIMS).
- Quality network for inpatient learning disability services (QNLD).
- Quality network for forensic mental health services.
- Quality network for psychiatric intensive care units.
- Star wards.

Over 20 wards were part of relevant accreditation schemes. Accreditation is given for individual wards so not all wards on a site are accredited by the relevant scheme.

Processes for managing risks, issues and performance

Risk management

A structure and process was in place to oversee performance, quality and risk. However, the structure did not support the executive board to effectively identify emerging performance, quality or risk issues.

There was no clear escalation process of risks from location level to the executive team. The process did not evidence that where risks were identified, the level of risk was identified and that this was mitigated at the correct level within the organisation.

This executive team did not have oversight of significant risks identified by regional teams. The provider used different information systems to notify and manage risks across the organisation. There was evidence that risks were discussed at a location and regional level. However,

records of recent regional and management meetings showed evidence of risks being escalated but not being entered on the corporate risk register. These included the high use of restraint identified within a region; doctors response times following the administration of rapid tranquilisation and the absence of CCTV in some areas. All were highlighted as organisational risks but were not included in the corporate risk register.

During inspection activity in locations we saw evidence of clinical, environmental and operational risks being identified and managed appropriately in most locations.

The corporate risk register did not clearly identify the risks to the organisation or the sustainability of services. The provider had a corporate risk register in place which we reviewed. The register was formed of location risks and actions being taken to address these. The risk register did not contain corporate risks in relation to the sustainability of its services. The risk register did not use any form of matrix to indicate the level or risk before and after any mitigating actions being taken by the provider.

Finance

Cygnet Health Care Limited is a financially sustainable organisation with increasing revenue and operating profit. A chief finance officer is in post and the organisation has submitted its accounts as required.

Cygnet Health Care Limited most recently published group financial results for year ending December 2017 showed a revenue of £334 million with an operating profit of £40 million (before significant items). The net assets of the organisation were reported as £394 million.

The financial statement included the acquisition of Cambian Adult Services and saw an increase in both revenue and operating profit from the year ending 31 December 2016. Cygnet Health Care Limited reported spending £36 million on capital expenditure (buildings and estates) in the year ending 31 December 2017.

The financial statement for the year ending 31 December 2018 is yet to be published but will include the impact of the acquisition of the Danshell Group.

Performance

There were processes in place to manage current performance at a senior level within the organisation. Registered managers and hospital directors had performance measures which they reported against and which were regularly reviewed at a regional level. The corporate management board had oversight of performance across the organisation and key issues were also discussed in the fortnightly executive management meetings.

Key performance indicators were reported to the corporate management board and included 3 main areas quality, staffing and occupancy. The information related to performance was contained within the monthly data submitted to the executive team. The data gave limited oversight of performance over time, exception reporting or analysis of the data.

There was a significant referral to the CQC inspection and rating methodology as part of performance and governance processes within the organisation. The minutes of meetings did not evidence variations in performance at location or regional level being identified or the actions required being discussed.

The provider did demonstrate that where the CQC had raised concerns or found a breach of regulation, action was taken through the provision of additional resource and support, for example, through increased scrutiny from the quality assurance managers.

Each location was required to have an overarching local action plan. This action plan was intended to be the main action plan for each location and identified issues or concerns and actions being taken to address these. Each action was then rated to clearly indicate its progress. We were provided with an example of the overarching action plan, we could not confirm that these action plans were in place during location inspection activity prior to this well led review.

The provider performed well against improvement targets set by commissioners. In the year 2018 / 2019. Cygnet Health Care had successfully implemented 14 commissioning for quality and innovation (CQUIN) schemes across its services including the establishment of recovery colleges in a number of its locations.

A team of relationship managers worked with local commissioners to monitor the Cygnet Health Care's performance against contracts. Information including key

performance indicators and details of incidents were shared with commissioners by relationship managers. Any concerns raised by commissioners were fed back to the relevant managers for a response.

Engagement with the people who use services, the public, staff and external partners to support high-quality sustainable care

There were systems in place to obtain feedback from staff and people who used services.

Engagement with people who use services

Advocacy services were contracted from an external provider and made available to people who use Cygnet Health Care services. The advocacy provider submitted a bi annual summary report to the senior leadership team with details of their activity and the key themes being raised by people accessing advocates. During the period December 2018 to May 2019 the advocacy service reported that they completed an average of 149 advocacy sessions per service type (learning disabilities, eating disorder and personality disorder). This had been an increase in sessions offered from an average of 121 in the previous 6 months. Key themes raised with advocates included wards (any matter concerning a ward), treatment (any concern regarding care and treatment) and external (contacting external agencies).

The advocacy service reported to senior leaders that the people's council meetings established in hospitals had strengthened the service users say in how they want the units they live in to be run.

People's councils had been set up in many of Cygnet Health Care's services. The people's councils supported by experts by experience gave an opportunity for patients to give feedback regarding the service. In a number of inspections of services, we found established patient councils and evidence of improvements being made to services as a result of the work of the council. The advocacy service was available to provide support to patient representatives on councils and discuss how issues could be taken forward. The local patients' council was part of a planned structure which also included regional councils and a national people's council.

Experts by experience visited Cygnet's Health Care services to speak with patients about the care and treatment they received. Experts by experience were recruited (through nomination by Cygnet) and supported by a third-party organisation. An expert by experience lead was directly employed by Cygnet and reported to the director of nursing. The expert by experience lead co-ordinated the schedule of quality checking visits and ensured outcomes were shared with the senior management team. These visits looked at a number of areas of the patients' experience including the environment; staff; risks and when things go wrong; physical health; kindness, dignity, respect and support; involvement; recovery; meeting people's needs; concerns and complaints. Feedback was present from 21 visits made between 1 April 2019 and 20 June 2019. Activities carried out by expert by experience included attending people's council meetings, carers events and talking to both patients and staff in services.

Staff engagement

Cygnet Health Care carried out an employee engagement survey each year. The most recent staff engagement survey results (2019) was reported to the corporate management board in April 2019.

Participation in the survey was high with 70% of Cygnet Health Care and 64% of former Danshell Group staff (staff working in former Danshell Group locations were reported separately). It was also noted that the previous year's results were not directly comparable as staff from former Cambian Adult Services had been included for the first time in 2019, although had completed annual surveys prior to this date. Cygnet Health Care also reported a significant increase in the former Danshell group staff participation in the staff survey compared to the previous year.

The engagement survey asked staff for feedback on a number of areas including: their role, managers and workplace; responding to concerns; pay and benefits; health and wellbeing; communication and participation.

Cygnet Health Care celebrated both staff and service user involvement. An annual awards ceremony recognised service users who were involved in making improvements to the services and participating in engagement activities. The chief executive had introduced an "act of kindness" award for staff to recognise and encourage kindness within the organisation which had been in place for two years.

Cygnet Health Care Survey Results

An overall positive staff engagement score of 80% was achieved.

Are services well-led?

All areas showed an improved position except for pay (-2%), access to non-mandatory professional development (-1%), manager taking an interest in health and wellbeing (-1%), number of staff not suffering musculoskeletal problems (-3%), understanding Cygnet's values (-1%) and having access to My Cygnet system (-6%).

Areas of the survey to highlight are: acting on concerns raised by service users (85%); care of service users is Cygnet's priority (81%); knowing how to report concerns (96%) and encouraged to report errors, near misses or incidents (93%).

Former Danshell Group Survey Results

An overall positive staff engagement score of 78% was achieved.

All areas showed an improved position except for staff not experiencing bullying, harassment or abuse from service users (-4%), pay (-9%), number of staff not suffering musculoskeletal problems (-2%), understanding Cygnets values (-26%), having access to My Cygnet system (-57%) and participation (-1%). The executive team noted the understanding values and access to My Cygnet were expected at this point in the integration process following acquisition.

Areas of the survey to highlight are: acting on concerns raised by service users (88%); care of service users is Cygnet's priority (88%); knowing how to report concerns (97%) and encouraged to report errors, near misses or incidents (96%).

The head of rewards was working with suggestions from staff to improve the benefits offered to staff.

Staff engagement survey – friends and family

As part of the staff engagement survey staff were asked "if a friend or relative needed treatment I would be happy with the standard of care provided by Cygnet".

Of Cygnet Health Care staff (excluding former Danshell Group staff) 73% said they would be happy with the standard of care provided.

Of Cygnet Health Care staff (who joined from Danshell Group) 80% said they would be happy with the standard of care provided.

There was no evidence that results of the staff engagement survey were benchmarked against other similar staff engagement surveys outside of Cygnet Health Care.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance