Independent Health provider well-led assessment

InMind Limited

Unit 7
The Quadrant
Upper Culham Farm
Cockpole Green
Reading
Berkshire RG10 8NR

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Our findings

Overall summary

Inspected but not rated

This report describes our judgement of the quality of care given by this group of registered providers 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

Whilst there had been improvements at the service, the provider had not always achieved regulatory compliance at its hospitals.

The organisation lacked an overarching identity. The leadership had not communicated a clear strategy to staff. Staff felt that a lack of a clear strategy was causing anxiety within their teams.

There was a stark difference in morale and culture between leaders and staff. Whilst hospital directors and senior leaders were very positive and optimistic about the organisation, this was not shared by many staff working at the services. Staff did not feel engaged in decision making at an organisational level.

Governance at a board level did not have sufficient regard for risks relating to patients. There were no board level discussions about high levels of incidents, violence and self-harm at some of the services.

Staff turnover at a senior leadership level and at a service level was high. The chief medical officer and chief operating officer had left the organisation shortly before the assessment. Turnover at some of the services was above 25%.

The organisation did not have dedicated professional leadership roles at an executive level.

The organisation did not have sufficient systems in place to ensure that everyone involved in the organisation met the requirements of the fit and proper persons test. The organisation held minimal information about the qualifications and experience of senior leaders. The organisation had not carried out checks of senior leaders through the disclosure and barring service.

Staff did not always feel able to speak up and challenge the way things were done. Staff working within the services had little awareness of the role of the freedom to speak up guardian.

The provider did not collect data about the protected characteristics of staff or service users.

The provider did not have an overarching programme of work to monitor and reduce restrictive interventions.

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 develop a culture of continuous learning, improvement and innovation at the point of service delivery. 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 were knowledgeable about most issues and priorities for the services.

The leadership team had been in post for 18 months. During that time, they had made considerable progress in stabilising the organisation and addressing challenges in relation to patients' safety and commissioning.

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

Compliance rates for mandatory training were above 90% for all courses across the organisation.

There had been significant improvements in the governance at an organisational 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.

Data and notifications were submitted to external agencies.

Background to InMind Limited

InMind Healthcare Limited is an overarching company that incorporates a portfolio of five registered providers of health and social care services. The five providers within the InMind portfolio are registered with the Care Quality Commission to provide services across 8 locations. This includes 5 hospitals and 3 adult social care locations. Sturdee Community Hospital, Southleigh Community Independent Hospital and Woodleigh Community Independent Hospital provide long stay or rehabilitation wards for adults of working age. Waterloo Manor Independent Hospital provides long stay or rehabilitation wards for adults of working age and forensic inpatient or secure wards. Battersea Bridge House provides acute mental health wards.

At the time of our inspection, the overall breakdown of Care Quality Commission ratings for the 8 locations was as follows:

Provider	Location	Registered activities	Current overall rating
Hospitals			
Glancestyle Care Homes Limited	Southleigh Community Independent Hospital	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Treatment of disease, disorder or injury	Good
Glancestyle Care Homes Limited	Woodleigh Community Independent Hospital	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Treatment of disease, disorder or injury	Good
Waterloo Manor Limited	Waterloo Manor Independent Hospital	• 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
Sturdee Community Limited	Sturdee Community Hospital	• Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Treatment of disease, disorder or injury	Requires Improvement
Battersea Bridge House Limited	Battersea Bridge House	• Assessment or medical treatment for persons detained under the Mental Health Act 1983	Requires Improvement

		• Diagnostic and screening procedures • Treatment of disease, disorder or injury	
Adult Social Care			
Glancestyle Care Homes Limited	Purley View Nursing Home	• Accommodation for persons who require nursing or personal care • Treatment of disease, disorder or injurry	Good
Glancestyle Care Homes Limited	Beech Manor	• Accommodation for persons who require nursing or personal care • Treatment of disease, disorder or injury	Good
InMind Community Support Services Limited	InMind Community Support Services Limited	• Personal Care	Good

Analysis of the 'must do' actions in the CQC reports for all inspections of InMind services between February 2018 to December 2022 found there were a total of 64 breaches of regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were:

- 36 breaches of Regulation 12: Safe care and treatment
- 22 breaches of Regulation 17: Good governance
- 3 breaches of Regulation 18: Staffing
- 2 breaches of Regulation 13: Safeguarding
- 1 breach of Regulation 15: Premises and equipment

All of 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 12 Mental Health Act monitoring reports that took place between 4 March 2020 and 3 October 2023 at InMind locations registered to provide assessment or medical treatment for people detained under the Mental Health Act 1983. Within these reports, there were 48 concerns about the implementation of the Code of Practice. Of these:

- 21 related to empowerment and involvement
- 18 related to purpose and effectiveness
- 4 related to respect and dignity
- 4 related to efficiency and equity

- 1 concerned least restrictive practice

Three patients had raised concerns with Mental Health Act reviewers. These related to lack of access to ward information, transfer to a different hospital before their tribunal hearing and access to leave to attend an appointment.

All locations had a registered manager in post.

Our inspection team

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

The team was advised by a governance lead and executive reviewer. The governance lead had a professional background in nursing and experience of working at senior levels within the NHS and independent hospitals. The executive reviewer had a professional background in finance and worked at an executive level within the NHS.

How we carried out the inspection

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

- We attended a chief executive officer briefing
- We attended a hospital directors' meeting
- We attended a quality and safety committee meeting
- We facilitated 3 focus groups with InMind staff attended by 34 people
- We Interviewed 7 leaders within InMind
- We received feedback from 8 commissioners, who funded patient placements at 5 of the services.
- We reviewed board papers, dashboards, policies and other documents related to the running of the service.

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 a well-led assessment of InMind Limited as part of our risk-led schedule of independent health provider well-led assessments. InMind Limited was selected due to its inherent risk of caring for a range of vulnerable people with complex care needs.

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 regulations 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 there is sufficient stability in the leadership team. (Regulation 17).

The provider must ensure that risks relating to patients and clinical practice, including violence, self-harm and restrictive interventions, are reviewed at a board level. (Regulation 17)

The provider must ensure it has sufficient assurance that senior leaders are fit and proper people. (Regulation 19)

The provider must ensure that suitable arrangements are in place, so all staff are able to 'speak up' and raise concerns. (Regulation 17)

The provider must ensure that patients and service users are involved in decisions relating to the way services are carried out. (Regulation 9)

The provider must ensure arrangements for professional leadership across the organisation and ensure all professionals have access to clinical supervision and can access learning and development to support their continuing professional development. (Regulation 18)

The provider must be more pro-active approach to monitoring and reducing restrictive interventions. (Regulation 12)

The provider must ensure that it collates data and has due regard to the protected characteristics of its service users. (Regulation 10)

Action the provider SHOULD take to improve:

The provider should ensure that its overarching strategy linked to longer term plans for the organisation are communicated to staff and that steps are taken to improve morale within teams working at its services.

The provider should improve its arrangements for involving staff in organisational decision making and promoting equality, diversity and inclusion across the workforce. This includes developing its engagement with trade unions and the development of staff networks.

The provider should ensure it has appropriate arrangements develop a culture of continuous learning, improvement and innovation at the point of service delivery.

The provider should ensure that feedback from Mental Health Act Reviews are discussed at a board meetings. The implementation of provider action statements relating to these reviews should be monitored.

The provider should consider how it can introduce independent oversight of its governance processes to ensure they are suitably assured.

The provider should continue its efforts to address high staff turnover to ensure more stability within its workforce.

Is this organisation well-led?

Inspected but not rated

We did not rate the provider at this inspection.

Leadership

InMind was owned by two directors. One director was not actively involved in the company. In 2022, the company faced many challenges associated with the quality of services being delivered.

This included concerns raised by the coroner following the death of a patient, poor ratings from the CQC and concerns from commissioners. In response, the owner sought advice and assistance from the current chief executive to help in resolving these challenges. This led to the current chief executive and two deputy chief executives being engaged through a service level agreement to address the challenges and lead the development of the organisation. The board did not include non-executive directors to provide independent oversight.

Members of the executive leadership team had the appropriate range of skills, knowledge and experience to perform their roles. The Chief Executive Officer and Deputy Chief Executive Officers had been in their current roles for around 15 months. The Chief Executive had been the director of hospitals and social care services for over 20 years. In addition to their work at InMind, they owned a large portfolio of services including four independent mental health hospitals and approximately 50 care homes. They also owned the recruitment company used by InMind services. The two deputy chief executives had specific areas of responsibility. One deputy chief executive was responsible for clinical care and quality. They had been a consultant psychiatrist for over ten years and had previously worked as the clinical director of specialist services within a large NHS trust. The other deputy chief executive focussed on workforce, risk, business management and governance. They had a professional background in speech and language therapy, as well as extensive experience of managing projects and services across the NHS and independent health services.

The chief executive initiated collaboration between InMind services and the other services they owned or were involved with. The chief executive used a well-established governance model to ensure oversight of their other services. They had implemented this model at InMind. In addition, InMind services now used a healthcare recruitment agency that was owned by the Chief Executive. A deputy chief executive was working with the patient safety officer of another hospital owned by the chief executive to facilitate training on restraint.

The executive directors were able to describe their portfolios and areas of responsibility and reflect on areas of potential risk. When the executive team first became involved in InMind, each of the deputy chief executives took responsibility for a portfolio of four services. Once these services had permanent service directors in place, the portfolios of the deputy chief executives became more focused on leading specific areas of the business, such as workforce, governance, quality and clinical practice. These roles and responsibilities were set in within the corporate governance strategy.

They were able to articulate significant facts and figures relating to their portfolio. The executive team had a strong grasp of many of the key risks relating to all their services. They had a good grasp of key data relating, for example, to staffing and occupancy. The executive team also had a good, up to date awareness of the risks within their services. However, discussions at a board level tended to focus on operational and corporate matters. There was very little discussion to patients' risks, such as high levels of self-harm at one of the services.

The executive leadership team carried out visits to sites across the organisation. Some hospitals had required significant support from senior leaders, particularly when they had not had a permanent hospital director in post. On these occasions, a deputy chief executive was regularly on-site and took a very 'hands-on' management role. The chief operating officer had also been very visible at the services, visiting each service at least every three weeks. One of the deputy chief executives said they had visited each site on at least 20 occasions in the last 15 months. The

director had visited all eight services in the previous year. At each board meeting, members of the executive team gave feedback on the visits to services and discussions with patients. The notes of these meetings indicate that executive leaders had a good understanding of patients' needs and reflected on the outcomes being achieved for patients.

The executive team had sufficient capacity to deliver high-quality care and treatment. Capacity was managed by balancing the responsibilities of senior leaders and people working within services. The chief executive had an ethos of empowering people within their services to be responsible for all operational areas, and be less dependent on senior leaders. There were advantages within this ethos of reducing overheads and developing skills and experience of staff in the services. However, this approach contributed to concerns from staff about the lack of overarching identity for the organisation and a lack of professional leadership.

Clinical leadership had, until February 2024, been the responsibility of the group chief medical officer. The chief medical officer left the organization shortly before the inspection. This role had been assigned to a deputy chief executive, who had suitable experience and qualifications.

The turnover of senior leaders was high. For example, the chief medical officer left the organisation in February 2024. The chief operating officer left the organisation at the beginning of April 2024. Whilst the chief operating officer had been appointed on a short-term contract in order to implement new governance arrangements, limiting this appointment to three months meant that they were unable to embed the structures they had begun to implement.

InMind had basic systems in place to ensure their executive team had the necessary fit and proper person checks. Each director and member of the senior executive team had completed and signed a self-declaration form, confirming that they met the regulatory requirements for being considered a 'fit and proper' person. However, two of these declarations were signed and dated over a year after the person started in post. One declaration related to a previous employer. There was very little other information held on these records. For example, only one of the five records included a certificate from the Data and Barring Service (DBS). One record indicated that an application had been made to the DBS but this record did not include any details of the outcome of that application. Only one record indicated that references had been sought and received. The record for the deputy chief executive who was also acting as chief medical officer included their General Medical Council reference number, but there had been no checks of their qualifications. Only three records included details of the person's employment history.

The provider employed experienced hospital directors at each location. The executive team had made considerable changes to the team of hospital directors. A senior manager commented that there had been considerable improvements in operational management in the last 12 months. They stated that managers were more responsive to concerns and fully recognised the need for improvements. The organisation had recently held an away day with hospital directors to discuss the strategy.

At the time of the inspection, the directors did not have any specific plans in relation to succession. The service level agreement with the chief executive was initially planned to last for three years. This meant that there was just under two years remaining. The chief executive explained there may be scope to extend the service level agreement beyond the current timescale. He suggested that the directors could also enter into negotiations for the sale of the business. Since the inspection, the provider has agreed a longer term arrangement to incorporate InMind operations into the Chief Executives wider portfolio of services.

Nurse leadership across the organisation was not well established. Professional leadership took place within hospitals, not at an organisational level. Whilst discussions about professional practice development took place within each service, there was no structure or consistency to these arrangements. This meant that the executive team did not include a registered nurse. The decision to not employ a director of nursing was taken by the chief executive. This decision was consistent with their ethos of empowering staff within the services, rather than placing responsibility for professional practice within the senior leadership team. The chief executive had concluded that sufficient professional oversight was provided by employing a hospital director and a clinical lead for each hospital. However, we discussed this with the executive team. Shortly after our interviews, the provider began recruitment for a director of nursing. Their role will be to support and engage with nurses, ensure compliance and work with the training team to develop competencies for care workers.

The provider had assigned the role of professional lead for therapies to a psychologist in one of the services. This psychologist was reviewing supervision arrangements for psychologists working across the organisation. However, at the time of inspection, supervision arrangements were inconsistent. Some psychologists were able to purchase external supervision, whilst other psychologists received supervision from colleagues in similar roles at other hospitals.

There was no dedicated lead for social work within the organisation. However, hospitals did work collaboratively to ensure support and supervision took place within professional groups. For example, the social worker at one hospital supervised the social worker at another hospital nearby.

Vision and Strategy

InMind had a vision and set of values with quality and sustainability as the top priorities. The initial priority for the executive team had been to stabilise the organisation and ensure that services were safe. The executive team explained that, when they became involved, InMind was facing many challenges. Commissioners had given notice that they intended to withdraw funding from one of the hospitals. Other hospitals were in a poor state of repair. Serious incidents had occurred. The services were also using outdated systems for recording and monitoring. As a result, the immediate priority for the executive team was to stabilise the organisation, ensure that immediate safety concerns were addressed and ensure that commissioning arrangements were maintained. Members of the executive team described the initial stages of their work as ‘firefighting’. Since then, the organisation had made considerable progress. The provider had established a stable team of experienced hospital directors. Safety issues had been addressed. The provider had invested in an electronic records system that was being rolled out across the services. They had also secured continuing funding for all the services. However, strategic plans, or any sense of vision, had not been communicated across the organisation. Some staff said that a lack of clear direction and vision for the organisation was causing anxiety and concerns about job security. Staff felt the services predominantly worked in isolation, with a lack of shared identity or common purpose across the organisation. Furthermore, the values highlighted by the executive team of empowerment, compassion, inclusion and transparency were not reflected in the feedback from staff.

The provider had a commercial strategy. Senior managers had reviewed all the services and concluded that some models of long-term rehabilitation were becoming clinically out-dated. They

noted that commissioners were moving away from funding these services. The provider had also been concerned about the risks associated with providing stand-alone forensic services. Therefore, the commercial strategy focused on changing some hospitals from providing long-term rehabilitation services to acute mental health services. This change had been successfully completed at one of the hospitals during 2023. This change had involved considerable investment and taken place over 7 months. Changes were planned for two further hospitals in 2024. Architects and planners had visited these services to consider how necessary changes could be made to the hospital environments.

The provider had a clinical strategy. This focused on the recruitment of doctors and ensuring there were sufficient consultant psychiatrists in each service. The deputy chief executive responsible for clinical practice explained that there had been a lack of clinical management that had resulted in middle grade doctors acting up as consultants. All but one of the services now had a full compliment of doctors. A consultant was due to start at the remaining hospital in June 2024. They would be supported by three other doctors who would be in post shortly. A meeting for all doctors across the organisation had recently been set up. This took place every two weeks.

The provider was following a strategic approach to stabilising and improving the quality of the services. The chief executive explained that when they joined the organisation, they found that many staff were not suitably trained and environments at the services were very poor. They recognised that, in terms of quality, services had been a long way behind the National Health Service. Since then, the service had improved staff training, made changes at a hospital director level and improved environments. As part of the quality strategy the services were implementing a programme of new initiatives. This included changing all the services from paper-based recording systems to electronic care records, and a comprehensive programme of restraint training for all staff.

Workforce was one of the six priorities set out in the strategic plan for 2024-25. Over the previous year, the service had introduced initiatives to address issues relating to recruitment and retention. For example, the service worked closely with the Chief Executive’s recruitment agency to recruit new staff to all it’s services. The provider had recently completed a programme to recruit nurses and care workers from overseas. Other initiatives enabled employees to be paid for additional shifts within a week to encourage staff to cover gaps in rotas. The strategic plan included measures to develop these initiatives, as well as improving training, performance management and engagement with staff.

The provider did not have an environmental, social and governance strategy. There were no specific plans to deliver care in a more sustainable way.

InMind worked with a wide range of commissioners across the country. We received feedback from 8 commissioners who funded patients at 5 of the services. Seven of the 8 commissioners gave positive feedback. For example, one commissioner said they were impressed by communication they received from the hospital, particularly the weekly updates about each patient. Another commissioner commented that the hospital had a very good understanding of the patient’s needs. One commissioner had very specific concerns about the care given to a patient at one of the hospitals. The head of business development attended some collaborative meetings with commissioners, although most engagement with commissioners took place through hospital directors.

Culture

InMind did not specifically have a clear vision or set of values which were well embedded within the organisational culture. However, in all our interviews and focus groups, staff and leaders talked about their commitment to high quality services and achieving good outcomes for patients. Staff at all levels of the organisation spoke with a sense of pride about improvements to services and their achievements in helping patients in their recovery.

Many of the staff we spoke with had a different view of the organisation to hospital directors and senior leaders. Hospital directors were very positive about the organisation and had confidence in the senior leadership. They said that since the changes in leadership in 2022, there was more support from senior leaders and more consistency across the organisation. However, other staff we far less positive and raised significant concerns. For example, they said there were frequent changes in the senior leadership team and they did not know what areas senior leaders were responsible for. Staff told us about a situation when the hospital director had left their service suddenly with no explanation. They also said they found the arrangements for ownership of the organisation were opaque and they did not understand the status of the relationships with other organisations owned by senior leaders. Specific concerns related to the length of time it took to approve requests for expenditure on items needed for therapeutic activities. Staff were unhappy that sick pay had been reduced, overtime payments had reduced and there was a lack of parity between staff on old and new contracts. Most hospital directors were aware of these concerns and were looking for ways of addressing low morale.

Staff did not always feel able to speak up and challenge the way things are done at work. Staff said they had some confidence in their hospital directors and could raise concerns with them. However, they described situations where they had been made to feel obstructive when they raised concerns. For example, staff at a hospital providing long-term rehabilitation were concerned that the centralised bed management system had led to the hospital admitting patients with higher levels of acuity who were unsuitable for the service. They said this had led to some patients isolating in their rooms because other patients were agitated or shouting. Staff said these concerns had not been listened to.

The provider had a policy on reporting malpractice (whistle blowing/protected disclosure), although this did not specifically refer to the role of the freedom to speak up guardian. The policy set out the procedures for reporting and investigating concerns raised through whistleblowing. The service had assigned the role of freedom to speak up guardian to a deputy chief executive. Information about this role, including examples of concerns that should be raised, had been distributed to all services. Approximately 7 concerns had been raised with the freedom to speak up guardian since they undertook the role in February 2023. All of these concerns had been responded to and one concern had resulted in immediate changes being made. The chief executive explained that their telephone number is given to every service and that staff at these services were welcome to call him anytime. They said they received around 4-5 calls each week across their total workforce. However, staff were not always familiar with the arrangements for contacting the freedom to speak up guardian. Some staff said they would not feel comfortable raising concerns with them because they were not independent, and they had been involved in many of the decisions that staff were concerned about.

The provider had an external confidential whistleblowing line, through its employee assist programme. However, some staff said they would contact the Care Quality Commission if they had concerns, rather than use internal procedures.

InMind did not have any specific initiatives to promote equality, diversity and inclusion for either its staff or service users. It did not collect data about the protected characteristics of their staff or service users. However, the strategic plan for 2024-25 did set out the intention to offer diversity training and ensure the organisation followed inclusive recruitment practices. None of the staff we spoke with said they had experienced racism or discrimination within the organisation. They said they worked within culturally diverse teams, and that staff within these teams worked well together. One service held a staff forum and support worker meetings where concerns could be discussed. Staff said that, on some occasions, they experienced racism from patients. The organisation encouraged staff to always report this. At one service, incidents of racism were always discussed at a daily meeting. At the board meeting in January 2023, the board agreed there should be a 'zero tolerance' approach to racism.

Turnover across the organisation was high across all services. Two hospitals had turnover rates over 40%. Three services had turnover rates of around 25%.

InMind supported the delivery of learning and development for its staff. All staff had access to an online training platform. The service employed an in-house training team, and it conducted 'train the trainer' programmes to enable staff to disseminate training to their teams. Some training, such as the current programme delivering training on restraint, was carried out by specialist external providers. The provider ensured that all external training agencies had appropriate experience and accreditation. The executive team reviewed data on mandatory training. The mandatory training programme included 24 courses. This included training on basic life support, intermediate life support, physical interventions, safeguarding, infection prevention and control and person-centred care. Training on physical interventions was accredited by the British Institute for Learning Disabilities. Compliance rates for all these courses was above 90%.

Governance

The provider had a framework setting out the structure of governance meetings taking place in services and at an organisational level. This included standard agendas and the use of data to discuss trends in quality of care. A board meeting was held every three months. The executive team attended these meetings. During 2023, the director attended half of the meetings. The agenda for these meetings included a report from the chief executive, a report on patients' experiences, a risk and assurance report and a review of corporate risks. The minutes of these meetings show that board members had a good understanding of their services and were familiar with many specific issues relating to staffing and the environment. However, there were no discussions about patient incidents such as reportable serious incidents, investigations and learning from incidents or serious safeguarding concerns. Only one complaint was discussed during board meetings in 2023. This related to an investigation into a serious incident. A series of specific governance meetings were held, relating to quality and safety, workforce, medicines and bed management. The quality and safety committee had been established in July 2023 and met every three months. The meeting was chaired by the deputy chief executive responsible for clinical matters and attended by all the hospital directors. The committee reviewed reports for each service. These reports were presented in a standard format covering areas of good practice, challenges, areas for improvement and action being taken. Learning from incidents was also

discussed, as well as any themes or trends in incidents. For example, at the meeting in January 2024, one hospital highlighted an increase in falls that had been identified and explained the steps it was taking to monitor and address this. The committee also reviewed a dashboard for each hospital. This included data on incidents, self-harm, safeguarding matters and restrictive interventions.

In addition to the board meeting and sub-committees, a briefing call was held with the chief executive and senior leadership team every three weeks. During this call, the chief operating officer, head of quality and compliance, head of human resources, head of recruitment and the head of business development each gave a presentation about the performance within their area of responsibility. Matters discussed at this meeting included occupancy, staffing levels, audits, training compliance, suspensions and disciplinary investigations and recruitment. A deputy chief executive officer, who was also the acting medical director, provided an update on medical staffing and lessons learned from incidents. The director attended some of these meetings.

There were regular meetings between the chief executive and the director. However, these meetings were not minuted.

The governance processes brought together a range of data into a performance framework that was used to oversee site-level detail for all services across the provider. A data report was produced for each board meeting. The report covered key information, such as occupancy, incidents, supervision rates, vacancies, risks and use of agency staff, although the report did not give details of the period of time that it covered. However, this report was entirely numerical and did not include any narrative to accompany the data.

Hospital directors completed quality dashboards. These were updated each week. The quality dashboard had two components. The first covered patient safety indicators including data on incidents, self-harm, rapid tranquilisation and the use of other restrictive interventions. The second component covered occupancy rates, use of agency staff, patients on long-term enhanced observations, compliance with training on immediate life support and results of audits of care plans and risk assessments. These dashboards were reviewed at hospital directors' meetings.

InMind had arrangements in place to monitor the quality of its services. The provider had an internal compliance team, led by the head of quality. This team conducted audits and inspections of services, including out-of-hours visits.

Hospital directors and the chief operating officer discussed adverse events, such as complaints, deaths and safeguarding matters at the weekly hospital directors' meeting.

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. Matters relating to the Mental Health Act and Mental Capacity Act were reviewed at quarterly board meetings. For example, at the meeting in April 2023, the board discussed a specific concern relating to the authorisation of administering medicines to patient without their consent. The internal compliance team assessed compliance with this legislation as part of their quality and safety reviews. For example, the internal compliance team had noted that paperwork relating to searching patients was not consistent with the requirements of the Mental Health Act Code of Practice. This matter was reported to senior leaders who initiated a review of policies and procedures to ensure these concerns were addressed. However, the provider felt that further work was needed to ensure sufficient monitoring and oversight of the use of the Mental Health Act. They had recently assigned responsibility for the

oversight of the Act to a Mental Health Act Manager working at one of the hospitals. They would be leading a consistent approach to Mental Health Act audits.

The provider offered Mental Health Act and Mental Capacity Act training to staff. This training was mandatory for staff working in hospitals. Over 85% of staff at each hospital had completed this training.

In services where patients are detained under the Mental Health Act, the Care Quality Commission conducts regular Mental Health Act review visits to ensure compliance against the Code of Practice. There had been 12 Mental Health Act monitoring reports between March 2020 and October 2023. Within these reports, 48 individual issues were raised. The most common issues were empowerment and involvement, purpose and effectiveness and respect and dignity. These reports were not discussed in board meetings.

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. For example, in the 12 months from March 2023 to February 2024, InMind services had submitted 209 notifications to the Care Quality Commission, in accordance with the regulations for registration.

InMind had a complaints policy. Ten complaints had been submitted between October 2023 and March 2024. Investigations had been completed for five of these complaints. Four of the five investigation reports included a clear plan of actions to be taken, and three included lessons learned from the complaint. One complaint had led to disciplinary action against a member of staff. One service, in particular, received a high number of complaints.

Management of risk, issues and performance

InMind had systems to identify and escalate risk. The head of quality led a programme of quality audits and internal inspections in order to evaluate quality and identify risks. The internal compliance team conducted follow-up visits within 2 weeks to ensure high risks had been addressed, and within 4 weeks to ensure that medium risks were addressed. A post-internal inspection action report was sent to both the service and senior leadership team, followed by an action plan stating how concerns would be addressed. The compliance team assigned a red, amber or green rating for each service. Changes to these ratings were agreed at meetings with hospital directors, in response to agreed actions being completed. The head of quality highlighted improvements that had been made through this process. For example, the action plan for one service had reduced from having over 100 actions to just 3. At another service, the CQC had removed conditions on its registration after significant improvements had been made.

Risk registers were available at a site level. An overall risk register was maintained showing the risks for each of the services. At the end of February 2024, there were 97 risks included on the register. Over 80% of these risks were held by three hospitals. One hospital had 36 risks and two had 22. Service improvement plans fulfilled the role of a risk register for each service. These plans were updated each week to include details of progress and likely completion dates for each area of improvement. These plans were shared with senior leaders and discussed at the hospital directors meeting, the quality and safety committee meeting and chief executive briefing call. Risks were classified as business risks, staff risks and estate risks. Risks relating to specific patients were recorded and managed by multidisciplinary teams at each hospital.

Each service completed a programme of internal audits. This included audits of care records and records relating to the safe monitoring of patients who had received rapid tranquilisation. These audits were overseen by the head of quality.

The provider did not have an overarching corporate risk register. This meant there was no formal process for recognising and addressing the strategic risks associated with the current service level agreement with the chief executive. Whilst the chief executive gave assurance of their commitment to InMind, and personal loyalty and friendship towards the director, there remained a considerable risk that the entire leadership team could leave the organisation when the service level agreement comes to an end. This would involve the loss of the chief executive, deputy chief executives, head of quality and the head of business development at the same time. This would have a considerable impact on all the services.

The provider had an electronic system for staff to report safety incidents. An electronic system was used to record incidents. When staff recorded incidents, they used a ratings system to indicate the severity of the incident. Staff at each service reviewed incidents weekly. Reports of serious incidents were sent to senior managers. Complex incidents were discussed with senior managers and care co-ordinators. Staff could include environmental concerns in their report, which were then discussed at a senior level. Hospital directors felt this system worked well and that senior leaders responded quickly to any concerns.

Staff felt that the provider encouraged them to report errors, near misses or incidents. The provider employed a pharmacy to conduct monthly audits of medicines management. These audits included details of any medicine errors. Reports of these audits were reviewed each month at the quality and safety committee.

The organisation had made some progress towards addressing risk. For example, the use of agency staff had reduced considerably. When services did use agency staff, hospital directors were able to explain the specific reasons for this.

Senior managers discussed serious incidents at the monthly briefing call with the Chief Executive. For example, at the meeting in March, senior leaders discussed the lessons learned from deaths within the services over the last three years.

The provider had systems for identifying improvements that needed to be made following incidents. The provider conducted thorough investigations of serious incidents. The reports of these investigations included recommendations and lessons learned. Following one investigation, an email was sent to all consultant psychiatrists advising them to keep up to date with guidance on prescribing high doses of antipsychotic medicines. However, these reports were not discussed at board meetings and there was no evidence to show that the reports had been circulated across the organisation. There was no structure in place to monitor whether recommendations had been implemented.

Systems had been put in place to identify and learn from unexpected deaths. The provider conducted thorough investigations into serious incidents including patients' deaths. The reports of incidents included lessons learned and action plans to address any matters of concern that had led to the incident.

The provider had a high use of restrictive practices in some of its services. For example, data for one hospital indicated that in January 2024, there had been 136 incidents including 72 instances

of deliberate self-harm, 8 physical assaults on staff, 6 assaults by patients on other patients and 20 other acts of violence or aggression. Data for another hospital showed that in February 2024, rapid tranquilisation had been used on 14 occasions, there had been 24 restrictive interventions and 8 safeguarding referrals.

The provider monitored its use of restrictive practices. The data on the use of restrictive interventions was reviewed at the hospital directors meeting. Some services had introduced a programme of work to reduce restrictive interventions. For example, one service kept a restrictive practice log with the aim of identifying blanket restrictions being placed on people. However, the provider did not have an overarching programme to address restrictive practice.

Serious incidents were reported through the provider's incident reporting system and overseen by the managing directors and the executive board. The provider conducted comprehensive investigations following serious incidents. These investigations followed a standard format. They included a thorough review of all relevant notes and care records, as well as details of interviews with staff. The reports highlighted care delivery problems, service delivery problems, patient factors, team factors and communication factors. Each report included a list of lessons learned and recommendations. However, there was no evidence that specific incidents were discussed at board meetings.

The provider had an overarching oversight of safeguarding concerns. Safeguarding concerns were reported and managed at a service level. Safeguarding referrals were reported to the hospital directors' meetings and the Quality and Safety Committee meetings. However, safeguarding did not feature on the agenda for board meetings.

Safeguarding training compliance was monitored monthly. At the end of April 2024, over 96% of staff had completed mandatory training on safeguarding.

The leadership of infection prevention and control took place at a service level. Each service assigned a nurse to have oversight of infection prevention and control at that location. Matters relating to infection prevention and control were reviewed at service level clinical governance meetings. These matters were escalated to the Quality and Safety Committee when necessary.

The provider did not have an established a drugs and therapeutic committee. The consultant psychiatrist at each service was responsible for the oversight of prescribing medicines. This was monitored through local clinical governance meetings and escalated to the Quality and Safety Committee when necessary.

The annual accounts for the year ending 31 December 2022 show that InMind had an annual turnover of £27.4m. This had increased gradually from £23.9m in 2020 and £25.5m in 2021. However, profits had fluctuated significantly. In 2020 the company recorded a loss of £290,000. In 2021, it recorded a profit of £52,000. In 2022, it recorded a loss of £780,000. The company recorded a high proportion of its turnover as administrative expenses, amounting to between 35% and 38% during these three years. The accounts also show that in the year ending 31 December 2022, the number of medical and caring staff fell by 20% from 455 to 363.

Information Management

A system of electronic record keeping was being introduced across the organisation. This system was being introduced at one service at a time to allow the organisation to learn from the implementation at early adopter sites and make improvements in the implementation at other

sites. This implementation was monitored closely by a deputy chief executive. At the time of the inspection, two services had fully introduced the electronic system. Managers at those services felt the system was working well.

Information technology enabled services to record their work and produce data about their performance. For example, staff working in the human resources department could easily access live data about vacancies, risk and projects. This information was sent to the executive team every two weeks.

An incident reporting system had been introduced across the organisation and enabled some service user data to be extracted with relative ease. The collection and analysis of data was not time consuming.

The provider had comprehensive systems to ensure good standards of data protection. An information governance committee met every three months to review the storage of data and information. This group sent reports to the director. There had been no notifiable data breaches in the past year. The role of Caldicott Guardian was assigned to the chief executive.

Engagement

The provider was not engaged in any significant co-production with its patients and service users. Service user experience and involvement was a standard agenda item for board meetings. During these discussions, members of the executive team gave feedback on their engagement with patients during visits to services. However, although community meetings for staff and patients were held at each location, there were no specific initiatives to work collaboratively with patients. The executive team had discussed the importance of involving patients and services users in the appointment of staff at a senior level, but this had not yet been implemented.

InMind had some arrangements in place to gather the views of people who used their services. The internal compliance team met with patients, residents and carers during their internal compliance visits. During these visits they attended meetings with residents and patients, and they acted on any concerns that were raised. For example, the services have tried to address patients concerns about staff being overly restrictive. The head of quality said that, on the whole, patients and residents were happy with the services, but there were concerns with local issues, such as the quality of meals. Some services held events such as barbecues and family days to engage with patients' friends and families.

Advocates visited each of the services. They produced reports detailing the views of patients. The provider was seeking to include feedback from advocates more within the clinical governance process.

The provider did not have a systematic approach to staff engagement. Each service conducted a staff survey in the last year. However, there was no consistent approach to these surveys, with each service asking different questions and collating responses in different ways. This meant it was difficult to gain an overall understanding of staff views. Further, the number of staff who completed the staff survey varied considerably from 87% at one location to just 19% at another. The average completion rate was 51%. However, there were many positive responses. For example, staff responded positively to questions about receiving support from their colleagues. In some services, concerns were raised about improvements and trust between senior managers and employees. One service received a low score for job security.

Whilst hospital directors spoke positively about their work on strategic decision making, other staff said that engagement with senior leaders was poor. Staff said that policy changes were very 'top-down'. Whilst some staff said they had a vocal staff team, and they consulted on changes, most said that new policies had been written and introduced without consultation with staff. No reasons were given to staff for changes in policy and there were no systems for reviewing whether the policy was working. Consequently, staff felt that policies had been introduced that were not appropriate to meet the needs of their patients. Some staff felt that new systems were more bureaucratic, causing them to spend more time completing forms. Staff also said that new ways of working were introduced quickly, without support or training. However, the provider had some plans to address this by producing newsletters and memos for staff to improve communication.

Learning, continuous improvement and innovation

The provider did not have a consistent approach or methodology to learning, innovation or improvement across its services. The services did not use any consistent methodology for quality improvement initiatives. However, some services were engaged in programmes to ensure that staff were able to meet the specific needs of patients. For example, one service frequently admitted patients with emotionally unstable personality disorder. Nine staff at that service were completing a diploma in dialectical behavioural therapy (DBT) skills. Similarly, staff at a service that admitted patients with obsessive compulsive disorders were receiving specific training to support those patients.

The provider recognised the importance of focusing on improvement and innovation. There had been considerable improvements across the organisation in the 18 months prior to the inspection. This included introducing new governance processes, introducing electronic record systems and introducing a new programme of restraint training.