Priory Healthcare Limited

The Priory Hospital Southampton

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed. This inspection was to seek assurance about this decision and to identify learning about the DMA process.

We focused on two key questions during this visit. Was the service safe? And was the service well-led?

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

- There were not always enough staff on the wards. The provider was not always able to fill vacant shifts with bank and agency staff, which had put patients and staff at potential risk of harm.
- Some staff had not completed their required mandatory training, which included the provider's in house restraint training. In addition, some staff had not received regular 1:1 supervision or annual appraisals. This meant the provider could not be assured staff had the right skills, knowledge and experience to perform their role safely.
- Staff on the adult acute ward did not always manage risk consistently or in line with patient care plans. Safeguarding alerts were not always raised when needed.
- On Starling ward, we found staff had not always attempted to complete the required physical health observations after patients had received medicines by rapid tranquilisation. The provider's policy and national guidance requires staff to closely monitor the physical health of these patients because they are at heightened risk of physical health deterioration.
- Some governance processes and local policies were not well implemented. For example, safeguarding alerts were not always shared with the relevant stakeholders.
- There had been two incidents where staff on other wards had not readily responded to Skylark's emergency alarm when required. A protocol was in place but staff had not followed this.
- Leaders had not always managed risks well and could potentially impact patient safety. This included concerns raised by staff about site security, although actions and plans were being discussed.
- Staff did not always feel they were listened to by senior leaders and raised some concerns about the culture.

However:

- All three wards we visited were clean, well equipped, well-furnished and well maintained.
- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Patients said they were treated with compassion and kindness and felt respected.
- Staff used restraint only after attempts at de-escalation had failed.
- Incidents were reported and investigated. At ward level we found staff implemented learning following incidents.
- Staff knew and understood the provider's vision and values and how they applied to the work of their team.
- Managers engaged with local health and social care providers to help meet the needs of patients and plan services. Managers from the service participated in the work of the local transforming care partnership.
- Leaders were aware of most operational challenges and had plans in place to address them. For example, the provider was aware of staffing pressures and reviewed staffing levels regularly. New staff were being recruited and vacancy rates across the hospital were reducing.
- Skylark ward had gained accreditation with the Royal College of Psychiatrists', Quality Network for Eating Disorders (QED).

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement; • The service did not always have enough nursing staff on shift to ensure safe care and treatment could be provided. Despite the provider's efforts to recruit new staff and use agency and bank staff to fill gaps, planned staffing levels had not been met on some shifts. • Starling ward did not have a ligature risk assessment for the communal lounge which contained potential ligature risks. When we raised this with the provider, senior managers took steps to rectify the issue. • Staff had not always completed or stayed up to date with their mandatory training. For example, some staff had not completed the provider's training about the use of restrictive practices. • There were sometimes inconsistencies in the way individual patient risks were managed. • On Starling ward, patients' physical health was not always monitored after they had received medicines via rapid tranquilisation. This did not follow national guidelines and meant that patients may be at potential risk of harm. • Safeguarding alerts and notification to external bodies were not always raised when needed. • Staff had access to clinical information, but it was not always easy for them to maintain high quality clinical records. Agency staff on Starling ward did not have access to the electronic record keeping system. This added pressure to substantial staff. • Our findings demonstrated that governance processes did not always operate effectively at team level. This included the completion of staff supervisions and appraisals across the service to ensure staff were competent and fully supported in their role.

Summary of findings

- Leaders had not yet embedded clear systems to analyse whether the implementation of the providers restraint reduction strategy was having an impact on the number of restraints.
- Risks that effected the whole service were not always managed well. For example, following two incidents highlighting issues with site security and the delivery of high-risk items to reception.
- Some staff reported that they did not always feel respected, supported or valued.

However;

- Patients said staff treated them with compassion and kindness and they felt respected.
- Both wards were clean, suitably furnished and well maintained. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff used restraint only after attempts at de-escalation had not been successful.
- Incidents were reported and investigated. At ward level we found staff implemented learning following incidents.
- Staff knew and understood the provider's vision and values and how they applied to the work of their team.
- Managers engaged with local health and social care providers to help meet the needs of patients and plan services. Managers from the service participated in the work of the local transforming care partnership.
- Leaders were aware of most operational challenges and had plans in place to address them. For example, the provider was aware of staffing pressures and reviewed staffing levels regularly. New staff were being recruited and vacancy rates across the hospital were reducing.

Specialist eating disorder services — **Requires Improvement** 

Following the inspection of this service we re-rated safe and well led to requires improvement because;

Summary of findings

- Staffing levels on the wards were not always safe. For example, there had been some shifts where the actual number of registered nurses on shift did not meet the planned numbers.
- Some staff had not completed or kept up-to-date with some of the provider's mandatory training. This included the provider's training on reducing restrictive practice. Although restraint was not used frequently on the ward, staff should have received this training, particularly if they needed to respond to an emergency on the ward or incidents elsewhere in the hospital.
- Some governance processes did not operate robustly. This included the completion of competency checks for staff to ensure they were carrying out therapeutic observations and managing medicines safely and completion of staff appraisals.
- There had been two incidents where staff on other wards had not readily responded to Skylark's emergency alarm when required. Despite there being a protocol in place staff had not followed this.

However,

- The ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive interventions such as restraint, managed medicines well and followed good practice with respect to safeguarding.
- Patients had access to medical staff and staff could access out of hours support when needed.
- Patients said they felt safe. They said staff treated them with compassion and kindness, respected their privacy and dignity, and understood their individual needs. All staff on the ward were committed to providing good quality care to patients.
- The ward participated in accreditation schemes relevant to the service and learned from them. This included gaining accreditation with the Royal College of Psychiatrists', Quality Network for Eating Disorders (QED).

Summary of findings

- Improvements were being made to the service. This included more staff receiving supervisions and attending specialist training.
- The provider engaged with patients, staff and families and used feedback to make changes to the ward. Managers engaged well with other local health and social care providers to meet the needs of the local population.

Summary of findings

Contents

Summary of this inspection

Background to The Priory Hospital Southampton

The Priory Hospital Southampton provides specialist inpatient services for adults with acute mental health needs and adults with eating disorders.

The hospital is registered to provides the following regulated activities:

- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983;

The hospital has three inpatient wards providing two different services;

Acute wards for adults of working age:

- Sandpiper ward is a mixed sex ward with 17 beds, based on the first floor.
- Starling ward is based on the ground floor is mixed sex ward with 12 beds. This ward had opened in May 2022. At the time of our visit the bed numbers had been reduced to allow time for new staff to be recruited.

Specialist eating disorder services:

- Skylark ward is a mixed sex ward with 11 beds. At the time of our visit the bed numbers had been reduced to 9 beds.

We visited both services during this inspection.

A registered manager was in post at the time of inspection.

We last visited the service in October 2020 to complete a focused inspection of the child and adolescent mental health service based on Kingfisher ward. We did not find any breaches of regulation at this visit. Since then this ward had closed and reopened as Starling ward.

We last inspected the whole service in September 2019 where the services were rated as good overall.

What people who use the service say:

During the inspection we spoke to 7 patients. We attended a community meeting and reviewed meeting minutes and previous feedback collected by the provider. We also made observations of how staff interacted with patients and spoke with a patient advocate who visited the hospital regularly.

Acute wards for adults of working age:

Patients on Sandpiper ward said they felt safe. Most patients felt they were involved in decisions about their care. Some said that they did not always feel listened to. We also spoke to an advocate who visited the service who said patients were generally happy and felt staff listened to their concerns or comments.

Specialist eating disorder services:

Summary of this inspection

Patients on Skylark ward said staff were kind and they had access to treatment that met their needs. Patients felt safe and listened to by the team. However, patients did raise concerns that there had been incidents where the ward had not been fully staffed. Although this had not impacted their care directly, they felt this added pressure onto staff and could be an issue if there was an emergency.

How we carried out this inspection

We inspected both core services during this inspection. We looked at two of the key questions to understand how safe and how well-led the services were. During the inspection we;

- spoke with 7 patients from Sandpiper and Skylark wards.
- toured all three wards and completed checks on the safety of the environment.
- attended meetings including a multi-disciplinary team review on Skylark ward, a patient community meeting on Skylark ward and the morning managers meetings that covered all three wards.
- interviewed 22 staff members including nursing staff, ward managers and members of the wider management team.
- reviewed 17 records relating to the care and treatment of patients across the three wards.
- reviewed other data about the quality of the services

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

Areas for improvement

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

Action the service MUST take to improve hospital-wide:

- The provider must ensure the management of entry and exit to the site is safely managed; this includes the handling of deliveries to reception. (Regulation 15)

Action the service MUST take to improve acute services:

- The provider must ensure patients' physical health is checked appropriately after they have received medicines via rapid tranquilisation, in line with national good practice guidelines. (Regulation 12)

Action the service MUST take to improve acute and eating disorder services:

- The provider must ensure governance processes operate effectively and that local procedures and policies are met. This includes ensuring staff receive regular supervision and appraisals. (Regulation 17)
- The provider must ensure there is enough staff on each shift, who have completed the required training, to provide safe care and treatment to patients. (Regulation 18)
- The provider must ensure that processes for answering emergency alarms on wards are adhered to. (Regulation 12)

Action the service SHOULD take to improve acute and eating disorder services:

Summary of this inspection

- The provider should ensure all staff are able to access and maintain records in relation to patient's care and treatment.
- The provider should continue to work to develop a culture that helps staff feel supported and listened to.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Specialist eating disorder services	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

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

Requires Improvement

Safe	Requires Improvement
Well-led	Requires Improvement

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

Requires Improvement

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

Safe and clean care environments

Both wards were clean and suitably furnished and maintained.

Safety of the ward layout

Both wards had mixed sex accommodation. Staff took steps to mitigate potential risks associated with this and had female only lounges areas.

There were areas on both wards that could pose a risk for higher risk patients. For example, some bedroom doors on Sandpiper ward did not have anti-barricade door frames in place. There were also some blind spots in areas of the wards.

Staff were aware of these environmental risks and had reflected this in their admission criteria. Staff completed individual risk assessments and used enhanced observations to keep individual patients safe. Convex mirrors were also in place to mitigate some blind spots in communal areas. Staff had also received training in how to use ligature cutters and knew where they were located on each ward in case of an emergency.

Staff completed risk assessments of most areas of the wards and reduced the environmental risks identified. Starling ward could not provide a ligature risk assessment for the communal lounge at the time of the inspection. However, we were told that a new risk assessment would be completed the same day'.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Where appropriate, patients had access to laundry facilities, a gym and fully equipped kitchen.

Staff made sure cleaning records were up-to-date and the premises were clean. The hospital's housekeeping team attended the ward daily.

Staff followed the infection prevention and control policy, including handwashing. The provider had implemented clear procedures in relation to COVID-19 that prevented the spread of infection and followed national guidance.

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

Requires Improvement

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

The wards had a dedicated room for administering medicines, which were locked, secure and only accessible to authorised staff. Staff checked the medicine fridges and clinic room temperatures daily.

The designated clinical waste bin on Starling ward was full and the lid did not close. Notices on the ward stated the bin should be emptied when over three-quarters full. This did not follow good safety processes.

Safe staffing

The service did not always have enough nursing and support staff to keep patients safe. The provider was aware of staffing pressures and reviewed staffing levels regularly. New staff were being recruited and vacancy rates across the hospital were reducing.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. In the six months prior to the inspection we identified incidents on both Sandpiper and Starling wards where there were not enough staff rostered to work safely on the wards. During the six months before the inspection there had been six incidents reported where Sandpiper ward had been short staffed. Since opening in May 2022, there had also been nine incidents where there were too few staff working on Starling ward.

Although patients and staff felt most other areas of the ward were safe, they raised concerns about staffing levels and the general impact it had on the day to day running of the wards.

Managers were able to make adjustments to staffing levels based on the clinical needs of the patients, but sometimes there were not enough staff available to meet these increased staffing needs. Although processes to adjust staffing levels these were not always effective. Staff were sometimes asked to move between wards to provide support when needed and managers were not always aware of these last-minute changes.

Overall, the wards had increasing rates of bank and agency staff. In July 2022 the average proportion of shifts filled by agency staff on Sandpiper ward was 27% and Starling ward was 39%. We were told that there was an increase in agency usage due to greater observation needs of patients.

The provider was aware of these challenges and were working to recruit new staff to improve this. Vacancy levels had reduced on both wards. At the time of the inspection there were three registered nurse vacancies on Sandpiper ward and no nursing assistant vacancies. The provider had recruited to all three of these nursing posts. On Starling ward there were still some staff vacancies that had not been appointed to yet including two full time posts for registered nurses and one health care assistant role.

Despite the staffing challenges, patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

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

Requires Improvement

Managers requested staff familiar with the service where possible. Bank and agency staff had a local induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health.

Levels of sickness varied from month to month but were generally low.

Medical staff

The service had enough medical cover, which included out of hours. Doctors attended the wards quickly in an emergency. A new Consultant had been appointed to Starling ward.

Managers could access locum staff when they needed additional medical cover. Medical staff told us all locum staff had a full induction and understood the service before starting their shift.

Patients said they could speak with medical staff and had their care reviewed on a regular basis.

Mandatory training

Staff did not always keep up to date with some mandatory training.

Not all staff were up-to-date with their mandatory training. For example, on Sandpiper ward only 47% of staff had completed their restraint and breakaway training and on Starling ward 75% of staff had completed this training. On Sandpiper ward 59% of staff had completed the provider's infection prevention and control training. These rates were below the provider's target of 95% staff having completed mandatory training.

It was also unclear how many staff had completed the full training in the use of evacuation chairs. These are aids used to help evacuate patients with reduced mobility in case of a fire. The ward was located on the top floor of the hospital with no access via a lift and patients were sometimes admitted with reduced mobility due to their condition. This potentially put staff and patients at risk in the event of a fire.

The ward manager was aware of some gaps around completion of mandatory training and had plans in place to improve staff compliance. The provider alerted staff when they needed to update their training and said some delays in staff completing training were due to COVID-19 disrupting the delivery of face to face training sessions. Staff said they did not always get the time to complete mandatory training.

Assessing and managing risk to patients and staff

Staff assessed risks to patients and themselves well but there were inconsistencies in the way individual patient risks were managed. Staff used restrictive practices only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident.

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

Requires Improvement

Risk assessments were individual, person centred and reviewed regularly. Staff knew the risks to patients and the actions needed to reduce or remove the risk. Individual risk assessments were completed for choking, physical health risks and activities such as external trips.

Management of patient risk

Patient risk was discussed daily in the morning safety meeting. Staff we spoke with understood patient's care plans and knew how to support each patient to reduce their risks. Although staff knew about potential risks to each individual patient, these were not always managed appropriately. For example, on Sandpiper ward there had been an incident where members of the therapy team had allowed patients to purchase restricted items whilst on leave and had not informed nursing staff on their return. On Starling ward, we found some items had been removed from the patients' kitchen in response to individual risks, but others had not. When we asked staff on the ward about this, they were not aware of the rationale behind this decision.

Staff did not always follow The National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation medicines. On Starling ward staff did not always review the effects of medicines on each patient's mental and physical health following rapid tranquilisation. We found examples where staff had not completed full physical health checks following the administration of rapid tranquilisation. This did not follow the provider's policy or national guidelines

Staff completed enhanced observations where needed to manage individual patient risks.

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

Staff used the National Early Warning Score (NEWS2) to monitor the physical health of patients. The use of NEWS2 was encouraged to assess the physical deterioration of adults in acute mental health facilities. Ninety six percent of staff had completed training in NEWS2.

If a patient required transfer to a psychiatric intensive care unit (PICU) senior staff ensured the referral was completed as soon as possible. Due to bed pressures within the local area there had sometimes been delays in transferring patients to a PICU. Managers made clear attempts to reduce any delays.

Use of restrictive interventions

Some staff had not completed training in reducing restrictive practice and use of restraint. The provider did not have a seclusion facility and had utilised the patient lounge as a last resort. Some systems had not yet been implemented to analyse the use of restrictive practice.

On Sandpiper ward levels of restrictive interventions were generally low. In the 12 months prior to the inspection there had been 29 incidents of restraint and five incidents where rapid tranquilisation had been used.

Staff reported that patients on Starling ward were generally more acutely mentally unwell, which had led to an increase in incidents and use of restraint.

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

Requires Improvement

Despite staff being required to use restrictive interventions some staff had not completed the providers training in the use of restrictive interventions. On Sandpiper ward only 47% of eligible staff had completed their training while 75% had completed this training on Starling ward. Potentially this put patients at risk of avoidable harm. Staff also raised concerns that some agency members of staff were not familiar in how to use restraint and had not completed training in restraint.

There were no seclusion facilities. If an individual patient's risk increased the hospital worked with other providers to secure them a bed at a more suitable location for example, a PICU. However, on Starling Ward there had been one incident where a patient had required seclusion. Staff had used the female lounge to seclude the patient. This decision had been made as a last resort by the multidisciplinary team and closely monitored by senior staff to ensure the patient was safe as possible during this period.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff kept clear records when a restraint took place that were reviewed by managers.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

The provider had a clear restrictive interventions reduction programme, which met best practice standards. However, some systems to analyse whether the restraint reduction work was having an impact on the number of restraints, had not yet been embedded. The provider was starting work to introduce systems to allow this oversight at the time of our inspection.

Safeguarding

Not all staff had completed or stayed up to date with their safeguarding training. However, Staff acted to safeguard patients when needed.

Some staff had not completed full training on how to recognise and report abuse. Over 90% of nursing staff had completed level 2 training in safeguarding but only 67% of eligible staff had completed the level 3 combined safeguarding training across both wards.

However, despite some staff not completing their training, staff we spoke to were aware of their responsibilities in ensuring patients were safeguarded from abuse. They demonstrated how they recognised signs of abuse, raised safeguarding referrals and knew who to inform if they had concerns. We also found examples where staff had worked with other agencies to safeguard patients from abuse.

Staff on the ward knew how to recognise the signs of abuse, raise safeguarding referrals and who to inform if they had concerns.

Staff worked well with other agencies to protect patients from potential abuse.

We were told of an incident where staff were found to be sleeping on a night shift. The provider had failed to raise a safeguarding referral and other relevant notifications to external bodies following this incident.

Staff access to essential information

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

Requires Improvement

Permanent staff had access to clinical information, but it was not always easy for them to maintain high quality clinical records.

Staff could access the information they needed about each patient and were notified of any changes to care plans and risk profiles. Staff also attended a morning meeting to discuss patients' needs and handovers between shifts.

Care records were stored electronically. Some copies were kept on paper and there were sometimes delays in uploading paper records onto the electronic system as agency staff did not have access to electronic records.

On Sandpiper ward we found all records were up to date. Records on both wards were stored securely.

Staff said they were given the current information about each person and any changes were notified at the morning meeting and again during the evening handover.

When patients transferred to a new team, there were no delays in staff accessing their records.

However, on Starling ward, we found staff did not always have easy access to patient care records and some records were poorly organised. For example one patient had two copies of a care plan and it was unclear which was the most up to date. We also found some paper records relating to in the wrong patient's folder.

Agency health care assistants on Starling ward did not have access to the electronic record keeping system. Staff told us this added additional pressure to substantive staff who had to input records on behalf of agency staff. It also increased the potential for inaccuracies in records. We also found that one of the three patients on Starling ward had an additional 'keeping safe' care plan in place with no clear rationale as to why this had happened.

Medicines management

Staff did not always follow systems and processes in place to ensure safe storage and recording of medicines.

The service had systems and processes to prescribe and administer medicines safely, but some aspects of medicines management required improvement.

Deliveries of medicines had not always been well coordinated. We found one incident where a delivery of controlled medicine had been left by the courier at the hospital's reception unattended.

However, doctors reviewed each person's medicines and gave clear direction to staff about the medicines each patient was prescribed. Information about medicines was provided in accessible formats to each patient.

Staff followed national practice to check people had the correct medicines when they were admitted, or they moved between services. On admission there was a system in place to carry out reconciliation of medicines in line with national best practice.

Reporting incidents and learning from when things go wrong

Staff managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

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

Requires Improvement

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents. Patients and their families were involved in these investigations. Lessons learned and recommendations were discussed and shared in clinical governance meetings and ward team meetings.

Staff received feedback from investigation of incidents, both internal and external to the service.

There was evidence that changes had been made as a result of feedback. For example, on Sandpiper ward following an incident where staff had required police assistance, the team had noted there had been some confusion when communicating with them. In response the ward manager had contacted the local police force to discuss protocols and lines of communication to ensure more effective communication in the future.

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

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

Requires Improvement

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

Leadership

The turnover of leaders and managers within the last 12 months meant there had not always been consistent, experienced leadership capacity in place to support the running of the service.

The current senior leadership team had only been in place for a short length of time. The current Hospital Director had been in place for nine months, one ward manager had been a locum for 15 months, another ward manager had been in post since May following promotion and the third ward manager had transferred in May from another Priory site.

Leaders were visible in the day to day running of the service. Staff told us the new ward managers were visible on the ward and they felt supported by them. Ward managers told us they received support from ward managers, senior leadership team and Priory senior leadership team, when required.

Ward staff said more senior leaders visited the ward on a regular basis and were visible.

Vision and strategy

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

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

Requires Improvement

Staff understood and worked towards the provider's vision and values. Despite some issues we found, staff were committed to delivering person centred care to patients. The provider had a clear vision for the direction of the ward and plans in place to improve the service.

The Hospital Director was working with staff to re-embed a clear recovery care pathway at ward-level, that matched the provider's overall vision for the service.

Staff and patients had the opportunity to contribute to discussions about changes within the service.

Culture

Staff reported improvements in culture at ward level but raised some concerns about team dynamics within the wider hospital. Staff did not always feel respected, valued or supported.

Staff told us that morale had been affected by some of the operational pressures caused by staffing pressures and the wider effects of the COVID-19 pandemic.

During the inspection staff raised concerns with us regarding the culture across the hospital. We reviewed the most recent colleague survey reporting findings from 2021 which had a low response rate of 46%. Staff also gave feedback that communication from regional and department management teams was not always honest.

Some staff had not always had access to regular supervision, although this was improving; during June and July supervision rates had improved to 85% and 90% respectively. However, between February and May 2022 ward managers did not receive any supervision.

Some staff had requested to have their supervision with staff from another ward as they felt it could be difficult to discuss things with their line managers. Plans had been discussed to find ways to provide clinical and managerial supervision separately but had not yet been implemented. Staff said that although they were able to raise concerns to the manager or senior management team, they were not confident that they would be listened to if they did.

However, staff told us that morale across the service was slowly improving. They said there was a good culture at ward level, but they did not always feel supported and valued by other teams and departments.

The hospital wide staff survey results demonstrated that staff thought the senior leadership were taking the service in the right direction and that they could see themselves working at the service in twelve months' time.

Despite some of the concerns raised by staff about the culture all staff we spoke to were highly committed to providing good quality care to patients. Patients we spoke with said that staff treated them with respect and worked well together on the ward to provide them care.

Staff understood the whistle-blowing process for raising concerns.

Equality and diversity staff networks were available for staff and patients to engage with. For example, a staff LGBTQ+ network was in place across the provider. Staff completed training in equality and diversity and gave individual support to patients with protected characteristics.

Governance

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

Requires Improvement

Our findings demonstrated that governance processes did not always operate effectively at team level and that performance was not always managed well and not all risks were managed effectively.

Some governance processes did not operate effectively. For example, there were gaps in the completion of clinical supervision and appraisals for staff. Staff had not received an appraisal and some staff did not have access to regular supervision.

We reviewed appraisal rates and for 2021, 63% of staff had received an appraisal. At the time of the inspection staff hadn't yet received their appraisals for 2022.

In April 2022 8% of staff had received supervision, with 16% receiving supervision in May 2022.This had improved significantly to 84% in June and dropped slightly to 62% in July. However, in April and May 2022 ward managers did not receive supervision. On Starling ward in April no staff member received supervision. In May 8% received supervision which rose to 12% in June and then 83% in July. This meant leaders and managers could not always be assured staff had the right skills and support to safely perform their roles.

Managers did not always have access to up to date data on mandatory training compliance. Regular team meetings had not always taken place within the last 12 months. However, the new ward managers were ensuring more regular meetings were taking place.

Some audits were not always completed or used effectively to improve the service.

For example, the service did not have an audit programme for restraint. Each incident was discussed during the monthly clinical governance meetings, but the service could not effectively assure themselves of trends and actions to reduce restraint. In addition, the last infection, prevention and control audit had not been kept-up to date.

Regular ligature risk and environmental audits were completed for each ward. However, we found the ligature risk assessment for the lounge area on Starling ward was missing. We observed cables hanging from the television and games console. After the inspection we were told about how this risk had been mitigated and assured that the risk assessment had been completed.

However, the senior leadership team and managers ensured that information was shared between senior leaders and staff on wards.

The service held a range of meetings including daily morning safety meetings, which shared issues and concerns, identified actions and monitored progress. All wards had a framework of community meetings with patients, handover meetings, ward rounds and multidisciplinary meetings.

The ward manager attended local governance groups and meetings and fed back key messages to the ward team.

Management of risk, issues and performance

Risks were not always managed well.

There had been two separate incidents where deliveries of restricted items had been left unattended at the reception desk. This included blades for maintenance tools and controlled medicines. This had the potential to put patients at risk of harm.

Following our discussion about these concerns with the leadership team, we were told of actions taken to address these risks and about plans to discuss this during the August senior management meeting.

Staff also raised concerns that there were no reception staff to manage the entry and exit of people through the main hospital entrance out of hours or at weekends. Staff working on Sandpiper ward had been given responsibility to manage the entrance during these times and staff felt this was unsafe and added to their workload.

Prior to the inspection there had also been two incidents of patients managing to jump over the stairway banisters. During the inspection we observed work being carried out to erect a screen to the main stairwell. The company completing the works had fixed brackets to the staircase which identified a ligature risk. This meant patients could use the bracket to jump over the banisters. After the inspection we were informed the company were requested to return and remove them. During our second visit on 8 August 2022, we observed these brackets had been removed.

Staff maintained and had access to the risk register at directorate level. Staff at ward level could escalate concerns when required. However, staff concerns about the management of site security, specifically about the delivery of parcels and lack of reception staff at the weekend were not on the risk register.

Managers from other sites met on a weekly basis to discuss performance across the region. The management team had been attending these calls.

The service had contingency plans in place for emergencies. For example, updates to guidance and policies during the COVID-19 pandemic had reflected wider national guidance and staff had been aware of these changes.

Information management

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

Staff had access to enough computers to undertake their roles. Computer systems were secure, and staff had individual passwords to access the systems. Managers had access to information about incidents.

However, systems in place to record mandatory training compliance did not ensure managers had access to accurate records regarding staff's mandatory training. Managers said a restructure within the administration team had contributed to some of the delays in uploading training data.

Engagement

The provider engaged with patients, staff and families and used feedback to make changes to the ward. Managers engaged well with other local health and social care providers to meet the needs of the local population.

Staff participated in annual colleague surveys. We reviewed the latest 2021 survey and areas for improvement included: personal growth for staff, wellbeing of staff, positive changes from the previous survey results and staff engagement. However, feedback also included the need for greater access to training and a feeling of increased appreciation in their role.

The service worked closely with external stakeholders such as commissioners.

Staff had access to the provider's intranet which provided them with up-to-date information on items such as policy updates.

Patients and carers could access information about the service through the provider's website. The information available gave a brief description of the hospital and the contact details.

Patients told us that they were able to provide feedback at either the weekly community meetings or directly with staff. We reviewed community meeting minutes, which included details of requests and resolution of these.

Staff encouraged patients to give more formal feedback on the service by completing a post-discharge survey. Although the response rate was low.

The service liaised with an external provider collaborative to plan admissions and manage beds across the region. The ward manager met with ward managers from other acute services to share lessons learnt and ideas and fed these back to the ward.

Learning, continuous improvement and innovation

The managers worked together as a team to make improvements to the running of the service. We were told progress had been restricted by operational challenges such as recruitment and the wider effects of the COVID-19 pandemic.

Staff were encouraged to develop their skills in quality improvement and contribute to the quality improvement programme. Staff said they were given the time and opportunity to learn.

We were told of a new acute pathway quality dashboard which had been developed for the service. This had recently been tested and was not yet formally launched. Test results had been discussed with the senior management team and it was agreed to start using the dashboard in ward rounds in approximately six weeks' time.

All staff spoke with passion and determination to improve the service and felt confident they were able to improve the lives of people on their ward.

Requires Improvement

Specialist eating disorder services

Safe	Requires Improvement
Well-led	Requires Improvement

Are Specialist eating disorder services safe?

Requires Improvement

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

Safe and clean care environments

The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and reduced any risks they identified.

Some aspects of the ward environment were not suitable for higher risk patients, but staff had taken steps to mitigate potential risks. For example, some bedroom doors did not have observations panes in place, but staff ensured patients presenting with increased clinical risk were supported in these bedrooms where staff could easily observe that they were safe.

Staff were aware of these environmental risks and managed them well. Staff completed individual risk assessments and used enhanced observations to ensure individual patient risks were managed. Staff were aware of the environmental risks and had reflected this in the ward's admission criteria.

Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. Staff had also completed training on how to use ligature cutters and where they were kept on the ward.

The ward had mixed sex accommodation. Staff took steps to mitigate potential risks associated with this. However, some staff on the ward were not aware what arrangements were in place to ensure female patients had access to a single sex lounge, as required under the Mental Health Act 1983: Code of Practice paragraphs 8.25 – 8.26'. We raised this with managers who were able to outline arrangements that met the criteria of the Act which could be put in place for female patients, when there were male patients on the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. However, we were told about two incidents where staff from other wards had not responded in a timely way despite this being the provider's policy. The issue had also been raised at the managers meetings and discussed at ward team meetings.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. One bedroom had been closed whilst refurbishments were taking place. Where appropriate, patients had access to laundry facilities, a gym and fully equipped kitchen.

Staff made sure cleaning records were up-to-date and the premises were clean. The hospital's housekeeping team attended the ward daily.

Staff followed the infection prevention and control policy, including handwashing. The provider had implemented clear procedures in relation to COVID-19 that prevented the spread of infection and followed national guidance. The ward manager was the Infection Prevention and Control (IPC) lead for the hospital and had plans to implement further audits and checks across the site including regular hand hygiene audits.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Emergency equipment checks were completed every day during the night shift.

The ward had a dedicated room for administering medicines, which were locked, secure and only accessible to authorised staff. Staff checked the medicine fridges and clinic room temperatures daily.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not always have enough staff to keep patients safe. The provider was aware of staffing pressures and reviewed staffing levels regularly. New staff were being recruited and vacancy rates across the hospital were reducing.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. In the six months prior to the inspection, there had been 20 incidents reported by staff where staffing levels fell below those identified as required by the service. In July 2022 there had been one incident where there had been no registered nurses on the ward during a shift to support the healthcare assistants. This had put patients at potential risk of harm'

Although patients and staff felt most other areas of the ward were safe, they raised concerns about staffing levels and the general impact it had on the day to day running of the ward.

Managers were able to make adjustments to staffing levels based on the clinical needs of the patients, but sometimes there were not enough staff available to meet these increased staffing needs. Staff were sometimes asked to move between wards to provide support when needed, managers were not always aware of these last-minute changes.

The provider was aware of these challenges and were working to recruit new staff to improve this. At the time of the inspection the provider had recruited to all three of the vacant registered nursing posts, but new staff had not yet started. There were two vacancies for health care assistants.

Requires Improvement

Specialist eating disorder services

From Monday to Friday, senior staff attended a daily meeting to review staffing levels and made adjustments to mitigate potential risks where possible. At the time of the inspection, the ward had reduced admissions and had nine patients on the ward. This was to allow the induction of new staff. The ward was also moving towards a new fixed pattern rota to help staff and managers plan staffing on the ward further in advance.

Managers used bank and agency staff where possible to fill gaps in staff numbers. The average rate for agency staff usage in the six months prior to the inspection was 21%. At the time of the inspection it was 26%. Bank and agency staff received a local induction. Managers requested regular agency and bank staff were used to maintain consistency and continuity.

Despite some of the staffing challenges, patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Managers requested staff familiar with the service where possible. Bank and agency staff had a local induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health.

Levels of sickness varied from month to month but were generally low.

Medical staff

The service had enough medical cover including access to a doctor out of hours. A doctor was available to go to the ward quickly in an emergency.

Medical staff had experience and specialist knowledge of treating patients with eating disorders. Patients said they could speak with medical staff and had their care reviewed on a regular basis.

Managers could access locum staff when they needed additional medical cover. Medical staff told us all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff did not always keep up to date with some mandatory training.

Not all staff had completed or stayed up-to-date with their mandatory training. This included safe handling of medicines (74% of staff had completed this training); the providers reducing restraint and breakaway training (47% of staff had completed) and the provider's combined face to face safeguarding training (57% of staff had completed).

It was also unclear how many staff had completed the full training in the use of evacuation chairs. These are aids used to help evacuate patients with reduced mobility in case of a fire. The ward was located on the top floor of the hospital with no access via a lift and patients were sometimes admitted with reduced mobility due to their condition. This potentially put staff and patients at risk in the event of a fire.

The ward manager was aware of some gaps around completion of mandatory training and had plans in place to improve compliance. The provider alerted staff when they needed to update their training and said some delays in staff completing training were due to COVID-19 disrupting the delivery of face to face training sessions. Staff said they did not always get the time to complete mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff used rarely used restraint.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident.

Risk assessments were individual, person centred and reviewed regularly. Staff knew the risks to patients and the actions needed to reduce or remove the risk. Individual risk assessments were completed for choking, physical health risks and activities such as external trips.

The ward had a clear admission criteria in place to ensure patients were only admitted to the ward if the service was able to meet their identified needs. Ward staff worked with other local providers and agencies to plan admissions and ensure patients had access to services in the local area that met their needs and that staff could safely manage their individual clinical risks.

For example, staff had not yet completed specialist training in how to support and restrain patients who required nasogastric (NG) feeding. People with severe restrictive eating disorders may require this type of enteral feeding to provide lifesaving treatment. Therefore, the ward did not plan admissions for patients who required this kind of support.

Plans were in place to upskill staff in the delivery of NG feeding and other specialist interventions for people with eating disorders, but this had not yet been implemented at the time of the inspection.

Patients received support to manage specific risks associated with eating disorders. Staff were aware of patients at increased risk of self-harm and suicide and provided appropriate support and treatment to manage these risks safely.

Management of patient risk

Staff had a good understanding of patients' needs. Staff identified and responded to any changes in risks to, or posed by, patients using the service. Staff had awareness of the risks and potential complications of eating disorders.

Patient risk was discussed daily in the morning safety meeting. Staff we spoke with understood patient's care plans and knew how to support each patient to reduce their risks. Staff monitored patient's physical health and responded if patients started to deteriorate. Staff used an adapted scoring system based on national MaRSiPAN (The Management of Really Sick Patients with Anorexia Nervosa) guidelines to monitor patients psychical health.

If patients went on leave, staff would work with patients and their families to ensure clear plans were in place on how to respond if their needs changed whilst at home.

The provider also had plans to introduce a pathway on personality disorders to help staff better support patients with a personality disorder.

Patients on the ward told us, aside from the staff shortages, they felt staff supported them to manage their individual risks safely.

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

Use of restrictive interventions

Some staff had not completed training in reducing restrictive practice and use of restraint.

Only 46% of staff had completed the provider's mandatory training in restraint, de-escalation and breakaway techniques. Although levels of restrictive interventions were lower on Skylark ward without this training the provider could not be assured that staff knew how to restrain patients safely in the event of an emergency.

In addition, there was a safety pod based on the ward. A safety pod is a physical aid that helps improve staff and patient safety during restraint. Staff said they had not yet been trained in how to use the safety pod. When we raised this with senior staff, they said the use of safety pods was included in the providers mandatory restraint training.

However, levels of restrictive interventions were low. In the twelve months prior to the inspection there had been three incidents where staff had used low level restraints on the ward. There had been no incidents where staff used rapid tranquilisation or seclusion on the ward.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Due to the admission criteria, patients who were likely to need support using regular restraint were not admitted to the ward. This included patients who required support with Nasogastric (NG) feeding.

Some staff were medically exempt and were unable to restrain patients. Senior staff were aware of this and ensured enough staff who were able to safely restrain patients were rostered to work on each shift.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

The provider had a clear restrictive interventions reduction programme, which met best practice standards. However, leaders had not yet embedded clear systems to analyse whether the restraint reduction work was having an impact on the number of restraints. The provider was starting work to introduce systems to allow this oversight at the time of our inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Patients were safeguarded from abuse.

Staff had training on how to recognise and report abuse. Eighty-eight percent of staff had complete mandatory training on how to safeguard adults and children. However, only 57% of staff eligible for Level 3 safeguarding training had completed this course.

However, despite some staff not completing their training, staff we spoke to were aware of their responsibilities in ensuring patients were safeguarded from abuse. They demonstrated how they recognised signs of abuse, raised safeguarding referrals and knew who to inform if they had concerns. We also found examples where staff had worked with other agencies to safeguard patients from abuse.

Staff on the ward knew how to recognise the signs of abuse, raise safeguarding referrals and who to inform if they had concerns.

Staff worked well with other agencies to protect patients from potential abuse.

Staff access to essential information

Permanent staff had access to clinical information and maintained up to date clinical records.

Staff could access the information they needed about each patient and were notified of any changes to care plans and risk profiles. Staff also attended a morning meeting to discuss patients' needs and handovers between shifts.

Care records were stored electronically. Some copies were kept on paper and there were sometimes delays in uploading paper records onto the electronic system as agency staff did not have access to electronic records.

Agency health care assistants on Skylark ward did not have access to the electronic record keeping system. Staff told us this added additional pressure to substantive staff who had to input records on behalf of agency staff.

There had been one incident where staff on a shift had not been aware about a patient's individual needs. However, no significant harm had been caused to the patient and the team had implemented learning about improving handovers as a result.

Medicines management

Staff followed systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medicines on their physical health according to The National Institute for Health and Care Excellence (NICE) guidance.

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed all medicines and prescribing documents safely. Staff followed national practice to check patients had the correct medicines when they were admitted.

Staff learned from safety alerts and incidents to improve practice.

Requires Improvement

Specialist eating disorder services

Doctors reviewed each person's medicines and gave clear direction to staff about the medicines each patient was prescribed. Information about medicines was provided in accessible formats to each patient.

Although we did not identify incidents where there had been medicine errors that had significantly impacted patient welfare, medicine competency checks had not been completed for two members of nursing staff on the ward. The ward manager was aware of this and had planned to complete these checks shortly after the inspection.

Reporting incidents and learning from when things go wrong

Staff managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents. Patients and their families were involved in these investigations. Lessons learned and recommendations were discussed and shared in clinical governance meetings and ward team meetings.

Staff received feedback from investigation of incidents, both internal and external to the service.

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

Are Specialist eating disorder services well-led?

Requires Improvement

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

Leadership

The turnover of leaders and managers within the last 12 months meant there had not always been consistent, experienced leadership capacity in place to support the running of the service.

The current senior leadership team had only been in place for a short length of time.

The current Hospital Director had only been in post since October 2021. At the time of our inspection the Director of Clinical Services post was vacant. A new ward manager was in place on the Skylark ward, who had been in post for less than a month. This had impacted the ability of the leadership team to make improvements to the service. However, the Hospital Director had identified where improvements were needed, had developed was an action plan in conjunction with the ward managers and staff and actions were starting to be taken to make improvements.

However, leaders were visible in the day to day running of the service. Staff told us the new ward manager was visible on the ward and they felt positive about the direction of the ward. More senior leaders visited the ward on a regular basis and provided support when needed.

Vision and strategy

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

Staff understood and worked towards the provider's vision and values. Despite some issues we found, staff were committed to delivering person centred care to patients. The provider had a clear vision for the direction of the ward and plans in place to improve the service.

The Hospital Director was working with staff to re-embed a clear recovery care pathway at ward-level, that matched the provider's overall vision for the service.

Staff and patients had the opportunity to contribute to discussions about changes within the service.

Some members of staff on Skylark ward had recently completed training on the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) and were looking to embed this approach into patient treatment pathways. MANTRA is a NICE (The National Institute for Health and Care Excellence) recommended treatment of anorexia.

Culture

Staff reported improvements in morale and felt supported by the new ward manager but raised some concerns about the culture within the wider hospital. Despite this, all staff on the ward were committed to providing good quality care to patients.

Staff on the ward said morale had been affected by some operational pressures and the COVID-19 pandemic. They did not always feel supported and valued by other teams and departments in the hospital. Staff had not always had access to regular supervision.

During the inspection staff raised concerns with us regarding the culture across the hospital. We reviewed the most recent colleague survey reporting findings from 2021 which had a low response rate of 46%. Staff also gave feedback that communication from regional and department management teams was not always honest.

However, the new ward manager was aware of this feedback and had plans in place to staff morale, culture and provide staff better access to support. This included providing new training opportunities to staff and re-establishing regular ward team meetings. During June and July 2022 Skylark staff supervision rates had improved significantly. Staff agreed morale was improving following the arrival of the new ward manager.

The hospital wide staff survey results demonstrated that staff thought the senior leadership were taking the service in the right direction and that they could see themselves working at the service in twelve months' time.

All staff on the ward were committed to providing good quality care to patients. Patients we spoke with said that staff treated them with respect and worked well together on the ward to provide them care.

Staff understood the whistle-blowing process for raising concerns.

Equality and diversity staff networks were available for staff and patients to engage with. For example, a staff LGBTQ+ network was in place across the provider. Staff completed training in equality and diversity and gave individual support to patients with protected characteristics. The team on Skylark ward were looking to implement more events to raise awareness around equality and diversity.

Governance

Our findings demonstrated that governance processes did not always operate effectively at team level and that performance was not always managed well and not all risks were managed effectively.

Some governance processes had not been completed on time. For example, medicine competency checks were overdue for 2 members of nursing staff on the ward. Staff had not received an appraisal and some staff did not have access to regular supervision. Managers did not always have access to up to date data on mandatory training compliance. Regular team meetings had not always taken place within the last 12 months.

Audits were not always completed or used effectively to improve the service.

For example, the service did not have an audit programme for restraint. Each incident was discussed during the monthly clinical governance meetings, but the service could not effectively assure themselves of trends and actions to reduce restraint.

The senior leadership team and managers ensured that information was shared between senior leaders and staff on wards.

The service held a range of meetings including daily morning safety meetings, which shared issues and concerns, identified actions and monitored progress. All wards had a framework of community meetings with patients, handover meetings, ward rounds and multidisciplinary meetings.

The ward manager attended local governance groups and meetings and fed back key messages to the ward team. Audits were used on the ward to identify issues and staff acted in a timely way to rectify any issues identified.

Management of risk, issues and performance

Risks were not always managed well at site level.

There had been two separate incidents where deliveries of restricted items had been left unattended at the reception desk. This had the potential to put patients at risk of harm. Following our discussion about these concerns with the leadership team, we were told of actions taken to address these risks and about plans to discuss this during the August senior management meeting.

Staff also raised concerns that there were no reception staff to manage the entry and exit of people through the main hospital entrance out of hours or at weekends. Staff working on Sandpiper ward had been given responsibility to manage the entrance during these times and staff felt this was unsafe and added to their workload.

Prior to the inspection there had also been two incidents of patients managing to jump over the stairway banisters. During the inspection we observed work being carried out to erect a screen to the main stairwell. The company completing the works had fixed brackets to the staircase which identified a ligature risk. This meant patients could use the bracket to jump over the banisters. After the inspection we were informed the company were requested to return and remove them. During our second visit on 8 August 2022, we observed these brackets had been removed.

Staff maintained and had access to the risk register at directorate level. Staff at ward level could escalate concerns when required. However, staff concerns about the management of site security, specifically about the delivery of parcels and lack of reception staff at the weekend were not on the risk register.

However, we found that on Skylark ward management of risks at ward level was good. The ward manager had access to information about the safety and quality of the service delivered and met with other managers and leaders within the service to review ward performance. Staff at ward level could escalate concerns when required.

Managers from other sites met on a weekly basis to discuss performance across the region. The management team had been attending these calls.

The service had contingency plans in place for emergencies. For example, updates to guidance and policies during the COVID-19 pandemic had reflected wider national guidance and staff had been aware of these changes.

Information management

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

Staff had access to enough computers to undertake their roles. Computer systems were secure, and staff had individual passwords to access the systems. Managers had access to information about incidents.

However, systems in place to record mandatory training compliance did not ensure managers had access to accurate records regarding staff's mandatory training. Managers said a restructure within the administration team had contributed to some of the delays in uploading training data.

Engagement

The provider engaged with patients, staff and families and used feedback to make changes to the ward. Managers engaged well with other local health and social care providers to meet the needs of the local population.

The service liaised with an external provider collaborative to plan admissions and manage beds across the region. The ward manager met with ward managers from other eating disorders to share lessons learnt and ideas and fed these back to the ward.

Staff had access to the provider's intranet which provided them with up-to-date information on items such as policy updates.

Patients told us that they were able to provide feedback at either the weekly community meetings or directly with staff. We reviewed community meeting minutes, which included details of requests and resolution of these.

Requires Improvement

Specialist eating disorder services

Staff encouraged patients to give more formal feedback on the service by completing a post-discharge survey. Although the response rate was low.

Patients were involved with decisions about the service. Patients contributed to clinical governance meetings and were involved in service changes such as the recruitment process. Patients had redesigned the ward logo, been involved in the updating the patients' welcome packs and outlining the ward expectations.

Staff engaged with families and carers. A fortnightly carers group on Skylark ward had restarted to provide support to carers of patients and involve them with discussions about the service.

Learning, continuous improvement and innovation

Staff were making improvements to the service. The therapy team had plans in place to embed a specific care pathway for patients with personality disorders on the ward using Dialectical Behavioural Therapy (DBT). DBT is a type of talking therapy.

The ward participated in accreditation schemes relevant to the service and learned from them. This included gaining accreditation with the Royal College of Psychiatrists', Quality Network for Eating Disorders (QED).

Staff were encouraged to develop their skills in quality improvement and contribute to the quality improvement programme. Staff said they were given the time and opportunity to learn.

However, nursing staff noted that some improvements had been delayed by operational challenges and they did not always have time to participate in quality improvement activity. The ward manager was aware of this and had plans in place to increase quality improvement on the ward once new staff had been on boarded to the service.

All staff spoke with passion and determination to improve the service and felt confident they were able to improve the lives of people on their ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured entry and exit to the site was safely managed, this included the handling of deliveries at reception.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured patients' physical health had been checked appropriately after they have received medicines via rapid tranquilisation; this was not in line with national guidelines. • Processes for answering emergency alarms on wards had not always been adhered to.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not operated effective governance processes and some local procedures and policies had not been met. This included ensuring staff receive regular supervision and appraisals.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- The provider had not always ensured there was enough staff on each shift, who had completed the required training, to provide safe care and treatment to patients.