Cheadle Royal Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

Patients using the service told us that they were treated with kindness, dignity and respect. We observed that staff took time to communicate with patients in a respectful and compassionate manner. Patients were empowered to become active participants in their care which required good communication skills from staff to enable them to address patient needs effectively.

All patients underwent a thorough assessment of need, care plans were holistic and recovery oriented and included physical health assessments, these were completed in collaboration with the patients, progress was regularly reviewed. Regular multidisciplinary meetings were held and attendance by outside agencies was encouraged. Good communication was evident with external agencies such as local authorities and community mental health teams. Families and carers were involved in this process where appropriate. Advocacy services were accessible and available to support patients.

The hospital followed national guidelines on cleaning standards and monitoring procedures to provide and maintain a clean and appropriate environment to prevent and control healthcare associated infection. The wards were clean and tidy and there was an established cleaning regime. All clinic rooms were fully equipped with accessible emergency equipment which was maintained appropriately. Medicines were dispensed and stored securely and weekly audits were undertaken to ensure safe practice.

There were arrangements in place to provide safe and effective care in the event of a failure in major utilities, fire, flood or other emergencies. We had sight of the hospital's fire risk assessment, service evacuation plans and details of fire training for staff.

The ward environments were situated in older buildings and were subject to constraints in observation. These were effectively managed and risks mitigated with the use of observation and individual risk management planning. Regular environmental quality checks were conducted and patients were able to discuss and resolve environmental issues in community meetings. Ongoing refurbishment plans had seen improvements to the ward environments.

Staffing levels were determined using a staffing ladder model. Electronic rostering was used to support staff management and staffing was reviewed regularly to ensure there was enough staff with the relevant skills to deliver safe patient care. Patients were supported by a skilled multidisciplinary team of staff which included nursing, psychiatric, psychological, occupational and dietetic support. Staff were supported to deliver effective care and treatment they told us that they received meaningful and timely supervision and were supported to maintain their professional skills and experience.

Treatment practices including physical health care and prescribing practices were based on nationally recognised guidance. Care planning was holistic and positive risk management was evident. Care planning, risk and review were undertaken regularly and patients and their carers were involved in this process. Any identified spiritual needs and cultural requirements were supported and families and carers groups were active in the service.

Safeguarding processes were in place which reflected national guidance, and understood by all staff. There was a clear structure of reporting and responsibility for safeguarding adults and children. Any concerns relating to adult and child protection were communicated to the relevant protection agencies.

Restrictive practices were reviewed regularly and patients were involved in the process, the service had a patient representative who met with patients regularly and acted as their voice in communication with senior managers. Regular patient surveys and community meetings informed improvements in patient care across the hospital.

Referral systems and admission criteria were in place and admission waiting times monitored. Delayed discharges and length of stay was also monitored, procedures and strategies were in place to reduce the length of stay.

Staff were trained in and had a good understanding of the Mental Health Act and Mental Capacity Act. Staff followed

Summary of findings

local procedures and support was available from Mental Health Act administrators. Patients were given information and support to ensure appropriate representation and aid understanding of their rights.

There was an established governance structure with a defined hierarchy of reporting and decision making within the service. There were clear systems of accountability and senior managers were actively involved in the operational delivery of the service. There was a clear statement of visions and values, staff knew and understood the vision, values and strategic goals of the service. Processes and systems of accountability and governance were in place and performance management and quality reporting was clearly set out. Risks were identified and monitored. Performance issues were escalated and discussed at relevant governance forums and action taken to resolve concerns.

All staff we spoke with were positive about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments. The service was committed to improving the services on offer and continually improving the quality of care provided to patients.

However:

The hospital had a policy and action plan in place regarding reducing the use of restrictive practices including the use of restraint in line with national guidance. However on the child and adolescent mental health wards two patients reported painful holds were used during restraint. This raised concerns about the use of pain compliance in the form of wrists holds being taught to staff in the management of violence and aggression training.

- On the acute wards for adults of working age and psychiatric intensive care units and the child and adolescent mental health wards there was inconsistent monitoring and recording of physical observations following the use of rapid tranquilisation.
- On the acute wards for adults of working age and psychiatric intensive care units staff had not received training around personality disorders.
- Within the psychiatric intensive care units there were higher levels of seclusion reported than levels of restraint.
- On the long stay/rehabilitation mental health wards for working age adults, staff were not always specifying clearly the decisions leading to capacity assessments and recording the decisions made in patients' best interests when patients were assessed as lacking capacity.
- Food in the patients' kitchens was not always stored in a way that minimised risk of food borne viral infections.

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	**Good** 	We rated acute wards for adults of working age and psychiatric intensive care units as good because: Facilities were appropriate for use. Wards complied with same-sex guidance. Environments were clean and well maintained. Staff followed infection control procedures. Patients had individual bedrooms and access to a range of facilities including outside space. The environment and equipment was maintained and subject to regular maintenance. Risks were assessed and managed. Nurses completed risk assessments on admission which were regularly updated. Risk management plans were in place. Environmental risk assessments were undertaken including ligature point and blind spot audits. There were good safeguarding processes. Staff knew how to identify and report concerns. Patients were prescribed medication in line with national guidance. Prescribing was reviewed weekly by an external pharmacist. There were good medication management procedures. Medication stock levels were monitored and medication was stored appropriately. Patients were active participants in their care. Care plans were developed with patients. They reflected the findings of patient assessments and were reviewed regularly. Patients had access to independent advocacy services. Patient feedback on staff and the care they received was positive. Patients considered staff to be caring and supportive. Interactions between patients and staff were positive. Staff treated patients with kindness and dignity. Staff were supported to deliver care. Staff received mandatory training, supervision and performance appraisals. There was access to additional training. Managers had received leadership training. Ward staff worked well together and staff described a supportive environment.

Summary of findings

There was good adherence to the Mental Health Act and the Mental Capacity Act. Staff were supported by a Mental Health Act administrator.
There were processes and audits to ensure and evidence compliance with legislation.
There was a governance framework to support the delivery of care. An audit and assurance programme was in place. Adverse incidents were reported and reviewed. Compliance with mandatory training was monitored.
However:
There was inconsistent monitoring and recording of physical observations following the use of rapid tranquilisation.
Staff had not received training around personality disorders.
Within the psychiatric intensive care units there were higher levels of seclusion reported than levels of restraint.

Long stay/ rehabilitation mental health wards for working-age adults

Good

We rated long stay/rehabilitation mental health wards for working age adults as good because:
There were enough staff for patients to receive the care and treatment they required.
Staff identified ligature points (places where someone intent on self-harm might tie something to strangle themselves) and took action to remove or minimise risks.
The wards were clean and tidy and maintained to a high standard.
Staff were caring and treated patients in a respectful and dignified manner.
There was good multidisciplinary team working and staff engaged well with community teams as well as outside organisations.
There had only been one formal complaint in the last twelve months and patients told us that they were cared for by caring staff.
The clinical leadership on the ward was clear and all staff said that they felt supported and listened to.
Staff were aware of the provider's vision and values and were committed to providing good care in line with this.
However:

Summary of findings

Staff were not always specifying clearly the decisions leading to capacity assessments and recording the decisions made in patients' best interests when patients were assessed as lacking capacity.
Food in the patients' kitchens was not always stored in a way that minimised risk of food-borne viral infections.

Child and adolescent mental health wards

Good

We rated child and adolescent mental health wards as good because:
The wards were clean, tidy and well maintained. The clinic rooms were fully equipped and the emergency equipment was checked regularly. Staff were aware of how to report incidents and all staff had access to the online reporting system. There were single sex ensuite bedrooms with a separate female lounge in accordance with same sex guidance. There were good systems in place for ordering, delivering and storage of medications. Staff were aware of their responsibilities under duty of candour.
Staff completed a physical health check on admission and these were regularly reviewed. Mandatory training was all above 75% compliance and staff took part in clinical audits including medications, care records and Mental Health Act documentation. Staff had a good understanding of the Mental Health Act and the Mental Capacity Act. Mental Health Act documentation was completed correctly.
Staff engaged positively with patients and their carers. All interactions we observed were respectful and friendly. Carers and relatives told us that the staff were friendly and approachable and always took the time to speak to them and involve them in their loved ones care.
There were a range of rooms to support the care of the patients. This included activity rooms, quiet lounges and dining areas. There were activities on offer to patients seven days per week and this included evenings. Information was available in other formats if required for example in other languages, easy read format and braille. There was access to spiritual support and the chef was able to provide food for any specialist needs such as vegetarian, vegan, halal and kosher. Patients had

Summary of findings

access to an independent mental health advocate who visited the hospital and attended care programme approach meetings if patients wanted them to.
Staff were aware of the organisation's vision and values. Governance systems were in place to oversee the effective and safe care of patients. Managers felt empowered to carry out their role and equally were supported by the senior managers where required. Orchard ward had participated in the Royal College of Psychiatrists accreditation for in-patient child and adolescent services, demonstrating a commitment to quality and improvement. Staff knew who the senior management team were by name and reported that they visited the wards.
However:
We looked at records for three patients who had been administered medication for rapid tranquilisation. We found inconsistency in recording these incidents on the electronic care notes system. On occasion, nurses made an entry in the nursing notes but no incident report was made.
We checked ten post rapid tranquilisation physical health monitoring records. We could not find evidence of this monitoring on three occasions. Additionally, on two occasions all observations were recorded as refused, but the sedation score was not completed.
Two patients reported painful holds were used during restraint. We asked the hospital for more information about this including care plans for those patients, incident forms completed following incidents of restraint and evidence of referrals to safeguarding teams regarding these allegations. We were given assurances that the correct procedures were followed for those patients when these allegations were raised. However, we did have continuing concerns about the use of pain compliance in the form of wrists holds that was taught in the managing violence and aggression training across the Priory Group.

Summary of findings

Community-based mental health services for adults of working age

The Wellbeing Centre was located within the grounds of Cheadle Royal Hospital; the building was clean and pleasant and decorated to a high standard. Environmental checks were regularly undertaken, health and safety, risk assessments and monitoring was undertaken in line with hospital policy. Lone working procedures were in place.

Patients were protected from avoidable harm, and staff were supported to fulfil their responsibilities to raise concerns, report incidents and monitor and review risk. Lessons were learnt and communicated to all to improve services. Improvements to safety were made and changes monitored.

Safeguarding processes were in place which reflected national guidance, and understood by all staff. There was a clear structure of reporting and responsibility for safeguarding adults and children. Any concerns relating to adult and child protection were communicated to the relevant protection agencies.

Staffing levels and skills mix was planned, implemented and reviewed to keep people safe.

The service delivered a range of psychological therapies and had skilled staff to deliver these services. Risk to people who used the service was assessed and monitored, risk assessment was person centred and reviewed regularly. Plans were in place to respond to emergencies and major incidents.

The service was accessible and responsive and there was no delay from initial referral to assessment to treatment. Waiting times for patients wanting to access appropriate psychological therapies through the service, as part of their treatment were minimal.

Patients using the service told us that they were treated with kindness, dignity and respect. We observed that staff took time to communicate with patients in a respectful and compassionate manner. Appointments were scheduled at the patient's convenience and the service was open to patients in the evenings to support working patients.

Patients care and treatment was planned and delivered in line with current evidence based

Summary of findings

guidance. Information about patients care and treatment was routinely collected and monitored. It was easy for patients to complain or raise a concern about the service; complaints were taken seriously and responded to in a timely manner. Improvements were made to the quality of care in response to complaints to the service.
Staff were supported to deliver effective care and treatment they told us that they received meaningful and timely supervision and were supported to maintain their professional skills and experience.
There was a clear statement of visions and values, staff knew and understood the vision, values and strategic goals of the service. Processes and systems of accountability and governance were in place and performance management and quality reporting was clearly set out. Risks were identified and monitored. Performance issues were escalated and discussed at relevant governance forums and action taken to resolve concerns.
Staff we spoke with were all positive about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments. The service was committed to improving the services on offer and was looking at increasing accessibility of the service.

Specialist eating disorders services

Good

We rated the specialist eating disorders service as good because:
Both wards were clean, well maintained and homely. Difficulties in observations were mitigated with the use of CCTV, mirrors and individual risk management planning, six monthly environmental risk assessments were undertaken to ensure the safety of patients.
Both wards had fully equipped clinic rooms with accessible emergency equipment. Infection prevention and control procedures were followed. Medicines were dispensed and stored securely and weekly audits were undertaken to ensure safe practice.

Summary of findings

Staffing levels were determined using a staffing ladder model. Electronic rostering was used to support staff management and staffing was reviewed regularly to ensure there was enough staff with the relevant skills to deliver safe patient care. Patients were supported by a skilled multidisciplinary team of staff which included nursing, psychiatric, psychological, occupational and dietetic support.

Care planning was holistic and positive risk management was evident. Care planning, risk and review were undertaken regularly and patients and their carers were involved in this process. Any restrictive practices were reviewed regularly and patients were involved in the process.

Incidents were reported and monitored in line with hospital procedures. The service had not had any serious incidents in the previous year.

Safeguarding procedures were in place and staff received relevant training. Staff were supported by a safeguarding lead, there were facilities to enable child visiting.

All patients underwent a thorough assessment of need, care plans were holistic and recovery oriented and included physical health assessments, these were completed in collaboration with the patients, progress was regularly reviewed.

Records were stored electronically and information governance systems were in place to ensure the security of these records.

Treatment practices including physical health care and prescribing practices were based on nationally recognised guidance and followed the management of really sick patients with anorexia nervosa guidance. Standardised outcome measures were used to determine the efficacy of the treatments used.

Audit schedules and action planning were ongoing to ensure continuous quality improvement. The service was accredited by the quality network for eating disorders accreditation scheme in March 2017 (Royal College of Psychiatrists).

Summary of findings

Staff were skilled and experienced in working with people with eating disorders and all were up to date with mandatory training, and were supported by annual appraisal and regular clinical supervision.
Regular multidisciplinary meetings were held and attendance by outside agencies encouraged. Good communication was evident with external agencies such as local authorities and community mental health teams. Families and carers were involved in this process where appropriate.
Advocacy services were accessible and available to support patients.
Staff were trained in and had a good understanding of the Mental Health Act and Mental Capacity Act. Staff followed local procedures and support was available from Mental Health Act administrators. Patients were given information and support to ensure appropriate representation and aid understanding of their rights.
We observed and patients and carers told us that staff were polite, caring and respectful. They told us they were involved in care planning and had had enough information available to them to support them in treatment choice and decision making. Regular patient surveys and community meetings informed improvements in patient care.
Referral systems and admission criteria were in place and admission waiting times monitored. Delayed discharges and length of stay was also monitored, procedures and strategies were in place to reduce the length of stay.
The wards physical environment promoted recovery, comfort, dignity and confidentiality. Disabled access could be facilitated and designated rooms were available to people with limited mobility. Regular environmental quality checks were conducted and patients were able to discuss and resolve environmental issues in community meetings. Any identified spiritual needs and cultural requirements were supported and families and carers groups were active in the service.
Patients were informed of and aware of the complaints process. Complaints were seen by staff

Summary of findings

as an opportunity for patients to provide feedback about their care. Complaints received from patients and carers were continuously reviewed and acted upon to improve quality of care.
Staff spoke positively about their roles and were passionate about service development. Staff felt supported by senior members of the team. Staff were involved in the governance processes within the service. Their views were regularly sought and staff described good governance systems to support their commitment to quality care and subsequent service improvement.

Summary of findings

Contents

Good

Cheadle Royal Hospital

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards; Community-based mental health services for adults of working age; Specialist eating disorders services.

Summary of this inspection

Background to Cheadle Royal Hospital

Cheadle Royal Hospital which is part of Affinity Healthcare Limited (operating as the Priory group) was located in Cheshire and had been registered with the Care Quality Commission since December 2010.

The hospital was registered with the CQC to provide the following regulated activities:

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

• Treatment of disease, disorder or injury

The hospital provided:

Acute adult services for men and women:

- Willows ward male PICU with 10 beds
- Pankhurst ward female PICU with 10 beds
- Featherstone ward male PICU with 10 beds
- Maple mixed gender ward with 15 beds
- Alder mixed gender ward 14 beds

Child and adolescent mental health wards:

- Orchard mixed gender 15 beds
- Meadows ward mixed gender 10 beds
- Woodlands ward female low secure 10 beds

Specialist eating disorder services:

- Cedars mixed gender ward16 beds
- Aspen mixed gender ward 11 beds

Long stay rehabilitation wards for working adults, comprising of two houses:

- Elmswood House male 11 beds
- Elmswood View a male 6 beds

Community mental health services for all ages:

- The Wellbeing Centre

Since registration in 2010, the hospital had been inspected by CQC on seven occasions. The hospital has also been subject to 41 Mental Health Act review visits. The last inspection in February 2015, rated the hospital as good overall. There were no compliance actions/ requirement notices or enforcement associated with this service. Areas for improvement were noted:

The provider should ensure that staff have the appropriate training and understanding of the application of mental capacity assessments in respect of the Mental Capacity Act and the Mental Health Act.

The provider should ensure patients have a person centred holistic care plan in place to meet their needs within the CAMHS services and adult acute and Psychiatric Intensive Care Unit admission wards. The provider should ensure there is a clear autism pathway in place within the CAMHS service.

The provider should ensure that they successfully deliver the project to upgrade the seclusion facilities on Pankhurst, Meadows and Woodlands wards.

The provider should ensure that their recruitment plans for medical staffing on the adult PICU units are delivered.

The provider should ensure that identified ligatures are removed where possible.

The provider should ensure that the action plan to refurbish Meadows ward is completed

At this inspection we found that these actions had been undertaken.

Our inspection team

Team leader: Helen Duperouzel

The team that inspected the service comprised six CQC inspectors, two experts by experience and a CQC pharmacy inspector.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all the wards at the hospital and the community mental health service, looked at the quality of the environments and observed how staff were caring for patients;
- spoke with 45 patients who were using the service and 8 carers;
- spoke with the registered manager and managers for each of the wards;
- spoke with 82 other staff members; including doctors, advocacy services, nurses, dietitians, occupational therapist, pharmacist, psychologist and social worker;
- received feedback about the service from commissioners;
- spoke with independent advocates;
- attended and observed one multi-disciplinary meeting, one operations meeting and one community meeting, attended a group supervision session and a 48 hour review meeting;
- collected feedback from 7 patients using comment cards;
- looked at 68 care and treatment records of patients:
- carried out a specific check of the medication management on wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients told us that they were provided with care that was respectful and responsive to their preferences needs and values. Patients said they felt listened to and that their beliefs and cultural backgrounds were incorporated into the planning and delivery of care.

Most patients told us that they felt physically, emotionally and spiritually supported. Most staff were described as caring with some staff going above and beyond to help support, advocate and support their goals for recovery.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

we rated safe as requires improvement because:

- On the acute wards for adults of working age and psychiatric intensive care units and the child and adolescent mental health wards there was inconsistent monitoring and recording of physical observations following the use of rapid tranquilisation.
- On the child and adolescent mental health wards two patients reported painful holds were used during restraint raising concerns about the use of pain compliance in the form of wrists holds being taught to staff in the management of violence and aggression training.

However

- All ward areas were clean and well maintained and staff followed infection control procedures.
- Staffing levels were determined using a staffing ladder model. Electronic rostering was used to support staff management and staffing was reviewed regularly to ensure there was enough staff with the relevant skills to deliver safe patient care.
- Alarm systems were in place to summon assistance or call for help in an emergency. There were nurse call buttons in patient bedrooms and in communal areas.
- All incidents were recorded on the electronic incident recording system, these were reviewed regularly locally on an individual basis and hospital wide to discuss serious incidents and monitor themes and incident analysis. The provider had an open and transparent culture to reporting incidents and learning from incidents. Lessons learnt from incidents were shared across teams and staff described changes to policy and practice in response to lessons learnt.
- All staff we spoke with had an understanding of duty of candour at a level appropriate to their role. Staff were able to give examples of what would trigger a response under duty of candour and how this would be dealt with.
- Staff had received appropriate mandatory training;
- There was good medicines management practice on the wards. Medication was stored appropriately. There were procedures for the ordering and disposing of medication and a policy around controlled drugs. An external pharmacist visited each ward weekly.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Care plans were of a good quality, they were personalised, holistic and recovery orientated. There was strong evidence of patient involvement and patients were given copies of the documents.
- The wards followed best practice based on National Institute for Health and Care Excellence guidance when prescribing medication for patients. Appropriate outcome measures were used to monitor patients' progress and treatment outcomes.
- The provider had an annual audit programme. Audits completed in the year 2016 to 2017 included audits around the use of restraint, the reduction of restrictive practice, safeguarding and the management of patients with depression.
- There were weekly multidisciplinary ward rounds and regular care programme approach reviews for patients. Patients were able to access a range of treatments to support their recovery within a multi-disciplinary team approach.
- Staff were appropriately skilled for their role. Staff received regular appraisal and clinical supervision. The provider had a policy in place to manage poor staff performance and disciplinary issues.
- Patients had access to Independent Mental Health Act advocacy services. These were advertised on wards. Staff knew how to refer patients to the service. Patients we spoke with were aware of the advocacy services available.

Are services caring?

Good

We rated caring as good because:

- Overall, patient feedback was generally positive. Patients considered staff caring, compassionate and interested in their wellbeing. Patients reported that staff were respectful in their manner and treated them with dignity.
- Patients we talked with described staff they felt had been extremely supportive and gone above and beyond what they had expected.
- Patients told us they felt safe on the wards and were confident in the treatment they were receiving.
- Patients were orientated to the ward on their admission and welcome packs to help new patients settle into the

Summary of this inspection

environment and ward routine were available. Patients on the specialist eating disorder wards however felt unprepared for their admission to the service, staff told us they would review this and work with patients to improve their experience.

Patients were involved in their care. We saw evidence of patient involvement in care planning and the patients we spoke with knew what was in their care plan. Staff listened to patient views and responded to patient concerns. Patients were able to give feedback on the quality of the service they received. Patients were able to access advocacy services

Are services responsive?

Good

We rated responsive as good because:

- The wards provided a range of activities and facilities to meet patients' needs. Facilities were available to ensure safe child visiting arrangements were in place and cultural and religious needs were met. Disabled access was available in some ward areas although due to the nature and layout of some environments the service was not always able to admit patients with physical disabilities to all ward areas.
- Staff had access to translation services. This included face to face and telephone translation. Information leaflets were not routinely displayed in other languages. However, staff were able to access translation services to have documents translated where required.
- A complaints procedure was in place, all staff and patients were aware of the complaints process and felt that their complaints were taken seriously and were responded to in a timely manner. Themes from complaints received by the provider were discussed at monthly clinical governance and senior management team meetings where actions to address concerns were discussed and acted upon.
- Processes were in place to report, analyse and learn from adverse incidents, complaints and patient feedback. There was a hospital risk register in place. Ward managers were able to escalate risks through the governance structure to be included on the risk register. The risk register was reviewed monthly.
- Staff were able to give feedback on the service and input into service development. There was an annual staff survey facilitated by an external company and monthly staff forums and staff had seen chances in practice in response to their input.

Summary of this inspection

Are services well-led?

Good

We rated well led as good because:

- There was an established governance structure with a defined hierarchy of reporting and decision making within the service. There were clear systems of accountability and senior managers were actively involved in the operational delivery of the service. Processes and systems of accountability were in place and performance management and quality reporting was clearly set out. Risks were identified and monitored. Performance issues were escalated and discussed at relevant governance forums and action taken to resolve concerns.
- There was a clear statement of visions and values, staff knew and understood the vision, values and strategic goals of the service.
- All staff we spoke with were positive about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments. The service was committed to improving the services on offer and continually improving the quality of care provided to patients.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The service had a Mental Health Act administrator who had a lead role in maintaining processes and systems to support compliance with the Mental Health Act and the Code of Practice. The administrator led on the day to day administration of the Mental Health Act and was in receipt of Mental Health Act documents to ensure they were legally correct and valid. They ensured that mental health section expiry dates were dealt with within statutory timeframes and coordinated hospital manager reviews and mental health tribunals. The administrator conducted regular audits of issues such as ensuring patients' rights under the Mental Health Act were communicated to the patient and recorded. They also gave advice to staff and patients if requested.

Section 17 leave was recorded in the patients notes which included the conditions of leave and escort requirements. Multidisciplinary assessment of risk was undertaken prior to leave being granted and recorded in the patient notes. Conditions of leave were clearly recorded and leave was reviewed regularly as part of the multidisciplinary review.

Staff we spoke with had a good understanding of the Mental Health Act and associated Code of Practice. Mental Health Act training was a mandatory requirement and all staff were up to date with this training.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 requires health professionals to assess capacity, and determine best interests for an individual who lacks capacity to make a specific decision. A policy was in place to support staff when making decisions about the capacity of the patients in their care. Staff received training on the Mental Capacity Act and Deprivation of Liberty safeguards. Staff were able to describe the five leading principles of the act. Staff were able to describe situations where capacity would be assessed and how they would consider and implement capacity assessment and planning. Staff were aware of where to get advice about the Mental Capacity Act and Deprivation of Liberty and there were arrangements in place to monitor adherence to the Mental Capacity Act.

Patients capacity would be assessed on admission with ongoing assessment throughout their stay, although there were discrepancies noted in the recording of the decisions made and these did not always follow hospital procedures. Patients described their involvement in decision making and care and treatment records also detailed how patients were supported to make their own decisions about their care. Patients were aware of independent advocacy support they could access to safeguard their interests, and how to contact them.

There were no patients subject to the Deprivation of Liberty Safeguards at the time of our inspection.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	N/A	N/A	N/A	N/A	N/A	N/A
Specialist eating disorder services	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

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

Good

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

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Requires improvement

Safe and clean environment

Featherstone, Maple, Pankhurst and Willows wards were located in the main hospital building. Alder ward was located in a standalone building within the grounds. The buildings had not been designed for purpose but had been adapted to meet the needs of the patient group.

The layout of wards meant that staff were not able to observe all parts of the ward. However, this was managed by the use of convex mirrors, CCTV and enhanced staff observations. Each ward completed blind spot audits to identify and manage concerns. Staff we spoke with displayed a good knowledge of blind spots on their wards and were aware of the risks associated with them. Patients were risk assessed for the bedroom they were allocated.

There were ligature points on each of the wards. A ligature point is anything that patients could use to harm themselves by strangulation. Each ward had a ligature risk assessment in place which identified potential ligature points and appropriate actions to mitigate the risk. Anti-ligature knifes were available to staff. Staff knew where this equipment was and had been trained to use it.

Alder and Maple wards were mixed-sex wards. They were compliant with guidance on same-sex accommodation. Male and female sleeping areas were separate. Where bedrooms were not ensuite patients were able to access shower and toilet facilities without passing bedrooms of the opposite sex. There were separate female only lounges available.

Clinic rooms were clean, tidy and well organised. The rooms were well equipped and had facilities for monitoring patients physical health. This included blood pressure monitors, electrocardiogram machines and weighing scales. However on Pankhurst ward we found that the electrocardiogram machine was missing one of the leads. Staff had borrowed a machine from another ward to complete required physical health checks. A replacement lead had been ordered. Equipment was checked regularly and relevant maintenance regimes were in place. Not all clinic rooms had examination couches. Patients were examined in their own bedrooms when this was required.

Each ward stored emergency drugs and staff were aware of their location. Emergency drugs were checked regularly and were all in date. The temperature of the clinic rooms and medication fridges were monitored and recorded. The hospital had responded when temperatures exceeded limits and addressed the issue.

Featherstone, Pankhurst and Willows psychiatric intensive care units each had a seclusion room. If patients on Alder or Maple acute wards needed to access seclusion they used those facilities. Seclusion facilities used by patients met standards outlined in the Mental Health Act Code of Practice. Staff were able to observe patients whilst they were in seclusion.

Wards were clean and well maintained. Cleaning records were up to date and demonstrated that the wards were cleaned regularly. Staff adhered to infection control principles. There were hand sanitisers and personal

protective equipment available to staff. We observed staff following good infection control practice during our visit. Support was available from an infection control lead within the hospital.

Equipment, furniture and décor were generally in good condition and well maintained. Electrical safety checks had been carried out on all relevant equipment. Each ward had a fire risk assessment. Fire detection and fire-fighting equipment were maintained and subject to regular checks. There was a fire evacuation procedure in place and nominated fire wardens.

Each ward had controlled access and operated a signing in process for visitors. Personal alarms were available to staff and provided to inspectors. During our inspection all staff were carrying alarms.

Safe staffing

At the time of our inspection the staffing establishment and vacancy level for each ward was as follows:

Alder acute ward

Establishment levels for qualified nurses (whole time equivalent): 10.5

Establishment levels for nursing assistants (whole time equivalent): 11

Qualified nursing vacancies: 0.66

Nursing assistant vacancies: 0

Maple acute ward

Establishment levels for qualified nurses (whole time equivalent): 10.5

Establishment levels for nursing assistants (whole time equivalent): 13

Qualified nursing vacancies: 0.5

Nursing assistant vacancies: 0

Featherstone psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 8

Establishment levels for nursing assistants (whole time equivalent): 20

Qualified nursing vacancies: 1

Nursing assistant vacancies: 5

Pankhurst psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 10.5

Establishment levels for nursing assistants (whole time equivalent): 11

Qualified nursing vacancies: 0.63

Nursing assistant vacancies: 5.6

Willows psychiatric intensive care unit

Establishment levels for qualified nurses (whole time equivalent): 8.3

Establishment levels for nursing assistants (whole time equivalent): 15

Qualified nursing vacancies: 0

Nursing assistant vacancies: 2

Ward managers were able to access a cohort of bank and agency staff to provide cover or increase staffing numbers when required. The use of bank and agency staff was low across the service.

Wards operated a daily two shift pattern. The day shift ran from 7:30am to 8:00pm and the night shift ran from 7:30pm to 8:00am. On Alder and Maple acute wards there were two qualified staff and three healthcare assistants on the day shift. On Featherstone, Pankhurst and Willows psychiatric intensive care units there was an additional healthcare assistant on the day shift. All of the wards ran with one qualified staff member and three healthcare assistants on the night shift. Ward rotas showed that these staffing levels were being met.

Ward managers were able to adjust staffing levels daily in response to activity patient mix or clinical need. Wards were expected to manage a 1:1 patient observation from the existing staff numbers. However if there was more than one patient on the ward who required 1:1 observation additional staff were brought in to support this. We saw evidence of this in staffing rotas we reviewed.

Staffing numbers meant that there was always a qualified nurse available. Patients we spoke to told us that they were able to speak to nursing staff when they needed to. Patients had one-to-one time with key workers and this was recorded in care notes.

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

Good

The hospital provided a mandatory training programme for staff. Mandatory training covered a range of areas including safeguarding, basic or immediate life support, the prevention and management of violence and aggression and infection control. Overall compliance across the service was above 75%. There was one area which fell below that target. On Willows ward compliance with training on the prevention and management of violence and aggression was 60% (12 out of 20 staff).

Assessing and managing risk to patients and staff

Staff completed risk assessments of patients as part of the referral and admission process. We reviewed 26 care records during the inspection. Each care record had a risk assessment in place. Risk assessments were of a good quality, comprehensive and up-to-date. Where risks had been identified there was corresponding care plan to manage and reduce them. Relevant risks were highlighted to staff in the notes on a risk screen and on the ward patient information board.

There were some blanket restrictions in place across the service that were proportionate to the nature of the client base. There was a list of banned and restricted items which was available to patients and displayed on the ward. These included items such as sharp implements, illicit substances and razors. Patients on the acute wards had free access to their bedrooms. Free access to bedrooms on the psychiatric intensive care units was individually risk assessed. Patients on Alder and Maple ward had free access to their mobile phones. Patients on the psychiatric intensive care unit were able to bring in mobile phones providing they did not have cameras or recording capabilities. This had been raised an issue as most patient mobile phones included these functions. The hospital had a reducing restrictive practice group which met monthly. The issue of patient access to mobile phones was due to be discussed in that forum. The provider had a reducing restrictive practice policy.

Informal patients were able to leave the wards. Staff would speak to informal patients prior to them leaving. This enabled them to review patient risks. Notices explaining the rights of informal patients were on display.

The service had a policy for searching patients. Staff understood the policy. Patients were asked for permission to carry out a search. If the patient refused, staff completed a risk assessment to determine the need to proceed with a search. Staff had access to a metal detector wand as part of the search process. Patient belongings were searched on admission and recorded.

The hospital had an observation policy to support staff to determine and manage patient observation levels. Staff understood the policy. There were four levels of observation ranging from a minimum of four engagements per 24 hour period to constant observation (within arm's reach). Observation levels were reviewed regularly. Nurses could increase a patient observation levels in response to concerns. Observation levels could only be lowered by doctors. We observed staff carrying out observation duties during our inspection. Records we reviewed showed staff were following the policy and recording observations appropriately.

Staff were given training on the management of violence and aggression, the use of restraint and de-escalation techniques. A policy on the management of violence and aggression was in place to support staff. Verbal de-escalation was used as a first response. Restraint was only used when verbal de-escalation had failed.

Between 1 November 2016 and 30 April 2017 there had been 157 uses of restraint on 62 different patients within the acute and psychiatric intensive care wards. None of the restraints involved prone restraint. Figures for each ward were:

- Alder acute ward – ten incidents of restraint involving seven patients
- Maple acute ward – 65 incidents of restraint involving 15 patients
- Featherstone psychiatric intensive care unit – 33 incidents of restraint involving 16 patients
- Pankhurst psychiatric intensive care unit – 34 incidents of restraint involving 13 patients
- Willows psychiatric intensive care unit – 15 incidents of restraint involving 11 patients

Staff received training on the use of rapid tranquilisation. There was a policy in place to support the use of different medications and methods of administration. We reviewed five records where a patient had received rapid tranquillisation. We found that in three of the records although there was evidence in the client notes that the patient had been observed the rapid tranquilisation monitoring sheet had not been completed. As a result it

was not clear that the necessary physical monitoring had been taken to protect the patients' welfare. Incidents of rapid tranquilisation were not formally recorded however we were told that this was being reviewed.

Between 1 November 2016 and 30 April there had been 139 instances of seclusion. There had been no instances of long-term segregation. Figures for each ward were:

Alder acute ward – no incidents of seclusion

Maple acute ward – five incidents of seclusion

Featherstone psychiatric intensive care unit – 63 incidents of seclusion

Pankhurst psychiatric intensive care unit – 44 incidents of seclusion

Willows psychiatric intensive care unit – 27 incidents of seclusion

Within the psychiatric intensive care units there were higher levels of seclusion reported than levels of restraint. We discussed this with staff and patients during our inspection but it remained unclear as to why this might have been. Staff we spoke with consistently described a least restrictive approach to managing patient aggression. The first line of management was verbal de-escalation followed by restraint. Seclusion was considered a last resort. Patients we spoke with did not raise concerns that seclusion was being used inappropriately or before other avenues had been exhausted.

We reviewed seclusion logs and the records of four patients who had been secluded. The use of seclusion had been appropriate. Overall seclusion records were up to date and complete. Medical, nursing and multi-disciplinary reviews of the patient had been completed. Necessary observations were undertaken. However, it was not always clear that patients had been debriefed following the episode of seclusion.

Staff demonstrated a good understanding of safeguarding procedures and reported positive links with local safeguarding services. Staff were aware of different types of abuse and how to identify them. They were confident in raising safeguarding concerns and knew how to do so. There was a safeguarding policy; ward based safeguarding champions and a hospital-wide safeguarding lead to support staff. We saw examples in the case notes we reviewed of safeguarding issues being identified, reported and managed.

There was good medicines management practice on the wards. Medication was stored appropriately. There were procedures for the ordering and disposing of medication and a policy around controlled drugs. An external pharmacist visited each ward weekly. They reviewed prescription charts, provided advice and carried out checks on medication including stock levels. The pharmacist recorded any queries on an electronic system and responses were audited. The medicines management report for quarter one (April 2017 to June 2017) showed that 88% of pharmacist queries or interventions on Pankhurst and 23% of queries or interventions on Willows had not been recorded as acknowledged by ward staff. This had been discussed and actioned at the most recent medicines management committee.

Track record on safety

In the period between May 2016 and May 2017 the adult acute mental health and psychiatric intensive care units reported 137 serious incidents. 111 of these incidents related to violence and aggression. None of the serious incidents related to an unexpected patient death.

Incidents had been reviewed at an appropriate level and where required investigations had been completed. We spoke to staff who were able to give examples of changes in practice that had been made following an incident. For example risk assessments for patient leave had been changed from a five point assessment to a six point assessment following an incident.

Reporting incidents and learning from when things go wrong

The hospital used an electronic reporting system to record adverse incidents. The system was accessible to all staff. Staff we spoke with were able to tell us the types of incidents, including near misses that they would report and how they would do so.

Ward managers reviewed incidents. They could identify initial actions to address or learn from the issues raised. The hospital also held weekly and monthly governance meetings where adverse incidents were considered. This included the identification and analysis of trends in

incident reporting. For example the hospital had identified a trend around increased incidents in the evening time. In response the provision of evening activities on the wards had been increased. Hospital governance meetings were also used to monitor the implementation of identified actions from previous incidents.

Staff received feedback on adverse incidents they had submitted and on learning that had been identified. This took place through handovers, team meetings and in one to one supervision sessions. Staff and patients received debriefs after serious incidents when this was appropriate. Staff debriefs could be either one to one or in a group format and were facilitated by members of the psychology team.

Duty of candour

Duty of candour is a statutory requirement that ensures services are open and transparent with patients and carers. This includes informing patients about adverse incidents related to their care and treatment, providing support and offering an apology.

Staff we spoke with had an understanding of duty of candour at a level appropriate to their role. They understood their responsibilities to be open and transparent with people in relation to their care and were able to give examples of when duty of candour would be triggered. There were organisational procedures to ensure that the service met and recorded its obligations under duty of candour.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed 26 care records across the five wards. In all of the records, a comprehensive assessment had been carried out. Assessments had been reviewed and were reflected in care plans.

All of the records had care plans in place. There were different care plans available for different areas. For example there were care plans for keeping well, for keeping connected, for keeping healthy and for keeping safe. Care plans we reviewed were of a good quality. Care plans were personalised, holistic and recovery orientated. There was strong evidence of patient involvement and patients were given copies of the documents.

Staff carried out a physical health examination of patients. Physical health assessments were in place in all of the records we reviewed. Assessments were comprehensive and there was on going physical health monitoring were required. Patients with physical health conditions, for example diabetes or asthma, had specific care plans to meet their needs. Nurses administered discretionary (non-prescribed) medicines for the prompt relief of minor ailments such as dry skin, when required.

Patients were supported to use formal side-effect rating tools for reporting and monitoring side effects in order that these could be managed effectively. Nurses had access to leaflets and further medicines information from an electronic pharmacy database to share with patients.

The hospital used an electronic records system. Access to the system was password protected. Staff we spoke with told us they found the system easy to use and reliable. Some paper copies of records, for example Mental Health Act documentation were scanned onto the system and stored separately in secure locked cupboards.

Best practice in treatment and care

The ward followed best practice based on National Institute for Health and Care Excellence guidance when prescribing medication for patients.

We reviewed 29 prescription charts across the five wards. Prescribing was in line with National Institute for Health and Care Excellence guidance. Where it was required therapeutic drug monitoring was carried out and recorded. There was effective monitoring of high dose antipsychotic medicines where these were being prescribed.

There was a psychology service that was available to patients. Psychological interventions were delivered in both group and one to one formats and agreed within ward rounds. Therapies available included cognitive behaviour therapy, dialectical behaviour therapy, acceptance and commitment therapy, mindfulness and art therapy. There was a dialectical behaviour therapy skills pack that

healthcare assistants could utilise with patients. Psychological formulations were recorded on care records and shared with staff. Psychologists attended ward rounds when possible.

The provider had an annual audit programme. In the year 2016 to 2017 the service had completed audits around the use of restraint, the reduction of restrictive practice, the prevention of suicide, safeguarding and the management of patients with depression. Staff also undertook a number of audits on the ward. These included audits of care plans and infection control prevention and control measures. Medication and medication record audits were completed by an external pharmacy.

Staff used the health of the nation outcome scale to monitor patient progress and treatment outcomes. In addition, psychology staff utilised an outcome measure that looked at four key elements, well-being, symptoms, functioning and risk.

Skilled staff to deliver care

A range of professionals supported patient care. These included nurses, nursing assistants, occupational therapists, psychologists and consultant psychiatrists. An external pharmacist visited the wards weekly.

Staff were appropriately skilled for their role. The provider had a corporate induction, which new staff attended. We spoke to one new staff member. They told us they had received an appropriate induction and had been supported to settle in on their ward. They had been given copies of key policies and procedures and signed to confirm that they had read them.

Staff received regular managerial and clinical supervision. Wards had supervision structures in place and there was a provider policy to support the process. At the time of our inspection compliance with supervision across the service was 91%. Staff we spoke with told us they received regular supervision and that they found it meaningful. Qualified staff could access additional clinical supervision from individuals external to the ward. Psychologists also offered group supervision to staff. We observed one psychology led group supervision session for healthcare assistants. The session was well structured and offered staff the chance to discuss patients and interventions or activities that could help them.

Staff were able to access additional training to support their development and the delivery of care. Training needs were identified through the supervision and appraisal processes. We saw examples of staff who had accessed additional training around physical healthcare, phlebotomy and mentorship. However, staff we spoke to on Featherstone and Pankhurst psychiatric intensive care units expressed concern that they were admitting an increasing number of individual with a diagnosis of personality disorder. Staff had not received specialist training in the support and management of this patient group. We raised this with the hospital management who confirmed that this was being reviewed.

Staff received annual appraisals. All staff had had an appraisal. Staff completed appraisal documents that included their objectives, needs and a review of the previous years. Annual appraisals were signed off by both the appraise and appraiser.

The provider had a policy in place to manage poor staff performance and disciplinary issues. Team managers were able to access support from the provider's human resources team when required. Where appropriate poor performance was managed initially through supervision. There was a performance improvement plan to support poor individual staff performance where this was required. We spoke to two ward managers who had managed poor performance. They told us the process was effective and that they had received good support from the human resources team.

Multi-disciplinary and inter-agency team work

There were weekly multidisciplinary ward rounds and regular care programme approach reviews.

We observed one ward round. The meeting were well structured. Patients were involved in their meetings. There was input from a range of professionals including doctors, nursing staff, psychologists and occupational therapists. There was a comprehensive review of patients. Discussions were holistic and actions were agreed collaboratively.

Handovers occurred at the beginning of each shift. They were attended by all members of staff on duty. Handovers were well structured and demonstrated effective communication between staff on the two shifts. Staff gave an overview of each patient including risk, level of observation, change in presentation or circumstance and pertinent issues.

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

Good

Many patients resided outside of the local area. Staff we spoke with acknowledged that contact with out of area care coordinators could be difficult. Care co-ordinators were not always able to attend patient reviews in person. However, staff communicated with local care teams via telephone and email. Copies of records of meetings were shared appropriately.

Staff told us that there were good working relationships with other teams and services. This included other wards, local GPs and physical health services, pharmacy and local authority social services.

Adherence to the MHA and the MHA Code of Practice

Staff received Mental Health Act training as part of their mandatory training programme. Staff were fully compliant with Mental Health Act training.

Staff we spoke with demonstrated a good understanding of the Mental Health Act and the Code of Practice and were aware of their responsibilities under it.

Care records we reviewed detailed patient's detention under the Mental Health Act. Patients we spoke with were aware of their legal status and their rights under the Act. Staff regularly informed patients of their rights during their detention. Consent to treatment certificates were attached to medication cards. Patients with capacity had a T2 certificate to consent to the medication they had been prescribed. Where a patient lacks capacity a T3 certificate was used to confirm that a second opinion appointed doctor had reviewed the patient's medication and agreed the treatment plan.

There was a hospital Mental Health Act administrator and a central Mental Health Act team. Email reminders were sent to wards when patient sections were due to expire or patient needed to be informed of their rights. Compliance with the Mental Health Act was monitored through a series of audits. These included weekly audits by the administrator and external pharmacist, monthly audits by ward staff and quarterly reviews in documentation quality walk around. The findings of audits and compliance with the Mental Health Act were discussed in the monthly hospital clinical governance meeting.

Patients had access to Independent Mental Health Act advocacy services. These were advertised on wards. Staff knew how to refer patients to the service. Patients we spoke with were aware of the advocacy services available.

Good practice in applying the MCA

Staff received Mental Capacity Act training as part of their mandatory training programme. Staff were compliant with Mental Capacity Act training.

Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act and the five statutory principles. The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and how to access it. Support and advice could be sought from a central team.

Patient records showed that capacity was considered and that capacity assessments took place when required. We saw evidence that patients were supported to make decisions for themselves, for example through the provision of information in specific formats. Where required best interest assessments had taken place. However, details of these were sometimes not recorded within the care notes and ward round minutes. There was a separate form, referred to on the capacity assessment to record these. However, these forms had not always been completed. Restraint was carried out in line with the definition of restraint in the Mental Capacity Act.

Patients had access to Independent Mental Capacity Act advocacy services. These were advertised on wards. Staff knew how to refer patients to the service. Patients we spoke with were aware of the advocacy services available.

At the time of the inspection there were no patients subject to Deprivation of Liberty safeguards. Staff we spoke with demonstrated a good knowledge of the safeguards and knew when these may be used.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

We spoke with 17 patients who were using the service. Overall, patient feedback was positive. Patients considered staff caring, compassionate and interested in their wellbeing. Patients reported that staff were respectful in their manner and treated them with dignity. Patients we

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

Good

talked with described instances where they felt staff had been supportive and gone 'above and beyond' what they had expected. Patients told us they felt safe on the wards and were confident in the treatment they were receiving.

During the inspection we observed caring and positive interactions between staff and patients. Staff treated patients with respect and demonstrated an awareness of their individual circumstances. We observed one ward round and one 48 hour review meeting where patients were either present or discussed. Within these meetings, staff showed a good understanding of patient history and need. Patients and their cases were discussed professionally. Patients were encouraged to provide their viewpoint as part of the discussion.

The involvement of people in the care they receive

Patients were orientated to the ward on their admission. This included a tour of the ward area and introductions to staff and fellow patients. Wards also had welcome packs to help new patients settle into the environment and ward routine. Where possible patients were able to visit the ward prior to admission to begin the process early.

Patients were involved in their care. We saw evidence of patient involvement in care planning. Patients we spoke with knew what was in their care plan. We observed two meetings in which care was reviewed with patients. Patients were active participants in discussions and were given support to contribute. Staff listened to patient views and responded to patient concerns.

Patients were able to access advocacy services. Information on advocacy services and how to access them was available on the ward. This was in both poster and leaflet form. Staff we spoke with knew how to refer patients to advocacy services if they requested it. We spoke with one patient who had engaged with advocacy. They told us staff had supported them to do so.

Family members and carers of patients were involved in care and treatment where this was appropriate and agreed with the patient. Patients were able to give us examples where the involvement of family members and carers in discussions and decisions about their treatment had been facilitated. We also spoke to patients who did not want their family or carers involved. These wishes had been respected.

Patients were able to give feedback on the quality of the service they received. There were regular community meetings on each ward. Patients could use these meetings to raise concerns or make suggestions. Minutes of these meetings showed that identified actions had been followed up. Some of the wards we visited had 'you said, we did' boards on display. These detailed issues raised by patients and the actions taken by the service in response.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

During the period 12 November 2016 and 11 May 2017 the average bed occupancy across the service was 79%. The figures for each ward were:

- Alder acute ward – 87%
- Maple acute ward – 93%
- Featherstone psychiatric intensive care unit – 50%
- Pankhurst psychiatric intensive care unit – 84%
- Willows psychiatric intensive care unit – 80%

The average length of stay across the service was 38 days. Figures for each ward were:

- Alder acute ward – 39 days
- Maple acute ward – 38 days
- Featherstone psychiatric intensive care unit – 32 days
- Pankhurst psychiatric intensive care unit – 45 days
- Willows psychiatric intensive care unit – 39 days

During the period 1 November 2016 and 30 April 2017 there were 13 delayed discharges across the service. Figures for each ward were:

- Alder acute ward – four delayed discharges
- Maple acute ward – two delayed discharges
- Featherstone psychiatric intensive care unit – no delayed discharges
- Pankhurst psychiatric intensive care unit – four delayed discharges
- Willows psychiatric intensive care unit – three delayed discharges

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

Good

Delayed discharges were primarily due to awaiting an appropriate placement or support package from the patient's local area. Staff we spoke with told us that it could sometimes be difficult engaging local care co-ordinators. However, records we reviewed showed that staff communicated with local care teams regularly and followed up decisions or placements when required. We saw discharge planning considered in care notes and ward rounds. Patients we spoke with were able to discuss their discharge plans with us.

Patients on the acute wards were able to access a psychiatric intensive care unit on site if their needs changed. Beds were reserved when patients were on leave and available to them when they returned.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms to support treatment and care on each ward. These included lounges, dining areas and activity rooms. However, on some wards there were rooms used for dual purposes. For example there were rooms on some wards that were used for multidisciplinary meetings and also used as a quiet room or for visiting.

Each ward had access to rooms that could be used for visiting although these were not always within the ward environment. Patients were also able to meet visitors in the hospital café if this was supported by appropriate risk assessment. Patients were able to make phone calls in private. This was either by using their mobile phone, where permitted, in their bedrooms or by accessing the ward phone. Patients were able to personalise their bedrooms with pictures and posters.

Patients were able to access hot drinks and snacks on the wards. Patient feedback on food was mainly positive. However, some patients raised the fact that there was not always a hot meal option at each lunch time. On these occasions the menu was primarily sandwiches and salads. Patients had raised this issue in community meetings. There was a choice of hot meals in the evening. Menus were displayed a month in advance on the wards. The hospital was awarded a food hygiene rating of 5 (very good) by the local council in June 2016.

Activity schedules were on display on each ward. Nursing staff and occupational therapists provided activities. Activities available across the wards included creative groups, fitness sessions, smoothie making, relaxation sessions and games' groups. There was a reduced programme at weekends which was delivered by ward staff. Patients we spoke with told us they enjoyed the activities and found them beneficial.

Meeting the needs of all people who use the service

Due to the nature and layout of the environment the service was not always able to admit patients with physical disabilities. Some wards had assisted bathrooms and adaptations had been made to support patients with limited mobility. Patients with a disability who were referred to the service were individually assessed to see if their needs could be met. Referrers were aware of these limitations.

There was a range of information leaflets available on wards. These included information on mental health and mental illness, local support services, physical health, advocacy and how to make a complaint.

Staff had access to translation services. This included face to face and telephone translation. Information leaflets were not routinely displayed in other languages. However, staff were able to access translation services to have documents translated where required. Language needs were identified through referral and assessment information. Staff told us translation services were generally responsive and of a good quality.

Patient's dietary requirements were met. Staff were able to order food that met the needs of different religious and ethnic groups, for example meals made with halal meat. Patients had access to spiritual support. Local religious leaders had met with patients. Patients were supported to attend local places of worship if risk assessments deemed it appropriate. Patients had access to a multi-faith room on the hospital site.

Listening to and learning from concerns and complaints

During the period May 2016 to May 2017, the service received 41 complaints. In total five of the complaints were upheld and eight partially upheld. None of the complaints were referred to the Parliamentary and Health Service Ombudsman. Figures for each ward were:

- Alder acute ward – five complaints, one complaint partially upheld
- Maple acute ward – three complaints, one complaint upheld

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

Good

- Featherstone psychiatric intensive care unit – nine complaints, two complaints upheld
- Pankhurst psychiatric intensive care unit – 14 complaints, four complaints partially upheld
- Willows psychiatric intensive care unit – 10 complaints, two complaints upheld, three complaints partially upheld.

During the same period the service received 35 compliments. Figures for each ward were:

- Alder acute ward – six compliments
- Maple acute ward – 18 compliments
- Featherstone psychiatric intensive care unit – five compliments
- Pankhurst psychiatric intensive care unit – three compliments
- Willows psychiatric intensive care unit – three compliments.

There was a complaints policy in place. Staff we spoke with knew the policy and how to access the complaints department. Information about how to complain was displayed on wards and available in leaflet form. Patients we spoke with either knew how to complain or told us they would approach staff. We saw evidence that low level concerns that had not been raised as formal concerns were discussed in patient community meetings. Patients we spoke with told us they were comfortable raising concerns and felt that staff dealt with them appropriately.

Feedback from complaints and learning from complaint investigations was shared at team meetings, handovers and in supervision sessions.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

The hospital had an identified vision which was 'to make a real and lasting difference for everyone we support'. This was underpinned by five behavioural values. These were:

- putting people first
- being a family
- acting with integrity
- being positive
- striving for excellence

The provider had also developed divisional values in conjunction with staff. These were:

- we put safety first
- we value our people
- your voice matters
- we put people we care for at the centre of everything we do
- we take pride in what we do.. and celebrate our success

Staff we spoke with were aware of the vision and values. We observed staff delivering care in line with the vision and values.

Staff were able to tell us the names of senior managers within the hospital. However, not all staff felt they knew who the senior managers within the provider organisation were. Senior management at the hospital were visible and staff considered them approachable.

Good governance

There was a good governance structure to support the delivery of care. Governance meetings were held at service and hospital level. There was regular ongoing monitoring of performance and action plans in place to address concerns.

There was an audit programme to monitor compliance with local policies, national guidance and relevant legislation such as the Mental Health Act. Senior management and the provider's compliance team also carried out quality walk arounds. The provider had identified quality objectives for the year 2017 to 2018 and an action plan to achieve these was in place. However, we found that the hospital was not monitoring the use of rapid tranquilisation.

Processes were in place to report, analyse and learn from adverse incidents, complaints and patient feedback. There was a hospital risk register in place. Ward managers were able to escalate risks through the governance structure to be included on the risk register. The risk register was reviewed monthly.

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

Good

Staff were supported to deliver care. They received mandatory training and regular supervision and appraisal. There were sufficient staff on wards to manage the clinical need and provide one to one patient sessions.

In general ward managers told us they felt they had sufficient authority to run their wards and were supported by senior management. However, one ward manager felt they weren't supported in their clinical judgement over admissions.

Leadership, morale and staff engagement

Between the period 1 May 2016 and 30 April 2017 the staff sickness rate for the hospital was 4%. Ward managers we spoke with understood the provider's policy on staff sickness and how to manage those staff whose level of absence triggered its use. Mangers told us they were supported by the human resources department in that regard.

There were no bullying or harassment cases in the service at the time of our inspection. Staff morale was good. Staff we spoke with were positive about the service they provided and the teams they worked in. Managers and colleagues were considered supportive and helpful. Staff were aware of the hospital whistle blowing policy and process. Staff we spoke with told us that they would raise concerns without fear of victimisation.

The hospital offered leadership training for ward managers. We spoke with managers who had attended the training. They considered the courses to have been a useful experience. However, not all managers had attended the course.

Staff were able to give feedback on the service and input into service development. There was an annual staff survey facilitated by an external company and monthly staff forums. Staff were also able to give feedback in team and governance meetings as well as in supervision. In general staff we spoke with felt the provider was responsive to staff feedback. For example there had been changes to maternity pay following a staff survey.

Commitment to quality improvement and innovation

At the time of the inspection the wards were not involved in national quality programmes. Staff we spoke with told us that the hospital was reviewing whether or not to apply for accreditation with the Accreditation of Inpatient Mental Health Services scheme. The psychiatric intensive care units were members of the National Association of Psychiatric Intensive Care Units.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

Elmswood House and Elmswood View provided rehabilitation to patients with enduring mental health needs. The wards operated across two converted detached houses; each were over two floors. They were next to each other set in the grounds of the hospital. Both were well maintained providing a safe environment for delivering care.

There had been adaptions to the buildings to remove major risks including removing most ligature points. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. The remaining ligature points included some domestic taps and domestic restrictors on windows. However, these risks were mitigated by staff carrying out individualised admission assessments to ensure that only those patients who could safely be managed with these risks were accepted for admission.

The ward was regularly assessed for ligature points and observation plans were risk assessed against these points. There were ligature knives and wire cutters available in staff areas and staff knew where they were kept so staff could respond if an incident occurred. There had been no recent incident of patients tying a ligature. Patients told us that they felt safe.

There was CCTV in place within the communal areas of the ward with notices advising patients and visitors of its presence. CCTV from both wards could be viewed in Elmswood House but it was not used to replace staff observations of patients. It was used to examine incidents and resolve complaints. There was signage up to inform patients that CCTV was used.

The patients had personalised the communal and bedroom environments with a selection of prints in communal areas. In bedrooms, we found decorations which reflected personal choice and interests.

Clinic and activity rooms were provided in an adjacent building separated from the ward environment by a garden area. This encouraged a more home style life in the ward environment, which had a house style setting.

Medical emergency equipment was available and checked routinely as were fridge temperatures and were in full working order.

The wards were intended for patients with long term rehabilitation plans whom were able to engage meaningfully with the local community. Managers had therefore deemed that Elmswood House and Elmswood View would not have a seclusion facility. If patients' distress or behaviour could not be de-escalated, staff would look to transfer the patient to an appropriate mental health acute unit or psychiatric intensive care unit. Care plans showed that there were no patients with a current serious risk of violence and aggression.

All bedrooms had fire alarms and nurse call systems. We tested the call system on the top floor and staff responded

to the alarm within 90 seconds. This meant that staff responded well to the alarms when they were pressed. The ward regularly practiced scenarios for an event of an emergency situation.

Safe staffing

Staff worked across both Elmswood House and Elmswood View. Information provided by the hospital showed that with the increase in bed capacity with the introduction of Elmswood View, the staffing establishment levels across the units had been increased from seven to nine whole time qualified nurses excluding the ward manager and 16 whole time nursing assistants with an additional vacancy to be filled in September 2017. On each shift there were two qualified nursing staff and four nursing assistants working across the units. The daily allocation of staff on each unit reflected the number of occupied beds. At the time of the inspection there was one nursing assistant fully allocated to Elmswood View. They were supported by a qualified nurse who split their duties between the two wards. This reflected that Elmswood View was at 50% capacity at the time of inspection.

The hospital used an establishment tool to set the staffing levels for each ward. There was a core staffing level with additional staff being added to support agreed observation levels or activities such as escorted leave or trips.

Staff told us that there were rare occasions when they were short staffed, but there was usually enough staff on duty. Ward managers were empowered to use bank and occasionally agency staff to cover gaps, and these tended to be staff who had worked in the unit before. This meant that patients had continuity of care as the usage of bank and agency staff was minimal therefore patients knew their staff team and could build confidence within their relationship with them. Staff and patients told us leave or activities were never cancelled.

Patients were registered with a visiting GP who provided medical input for physical health conditions. A consultant psychiatrist provided responsible clinician input to the wards. The psychiatrist attended weekly and ensured that patients were reviewed at these meetings. During out of hours and when the psychiatrist was on leave or away, psychiatric input came from the doctor on call in the hospital. This arrangement was reported to work well with no concerns about delays in the on call medical arrangements.

The provider had a core programme of mandatory training for staff which covered subject areas such as safety, safeguarding, life support and mental health legislation.

The overall compliance rates for uptake of mandatory training for qualified and unqualified staff at Elmswood House and Elmswood View were above the providers compliance figure of 75% with lowest being 78% compliance for prevention management of violence and aggression training

Mandatory training uptake levels was monitored electronically, which enabled managers to view all team members and review compliance by individual, by team and by course. On a weekly basis, the site learning administrator issued weekly compliance reports to the managers on site who monitored the progress of their teams in complying with mandatory training.

Assessing and managing risk to patients and staff

We looked at eight care records. These all contained a risk assessment. Patient risk assessments were completed using a recognised risk assessment tool on admission and reviewed regularly to monitor any changes in risk. The risk assessments were updated to reflect any change in circumstances and a full review was held within the multidisciplinary team meeting. Risk assessments were person-centred, proportionate, reflected patients' cultural needs, and assessed patients' capacity to make decisions about their individual care. Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenged.

Patients were detained under the Mental Health Act. Elmswood House was a locked rehabilitation unit while Elmswood View was not, allowing patients free access to hospital grounds. Each ward followed the provider's observation policy, and patients had individualised observation plans reflecting their level of risk.

Restraint was not regularly used on the long stay and rehabilitation wards. In the six months up to August 2017, there had been four recorded incidents of restraint; none of these were prone or face down restraints. Staff confirmed that although there could be violent incidents, most incidents on the wards involved verbal aggression, and staff were skilled at de-escalating patients when they became agitated or distressed.

Long stay/rehabilitation mental health wards for working age adults

Good

The wards did not use seclusion or long-term segregation. Rapid tranquilisation was rarely used. Staff were aware of the policy for monitoring a patient if rapid tranquillisation was used.

We looked at thirteen prescription charts and associated authorities across Elmswood House and View. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, the relevant legal authorities for treatment were in place.

The ward received regular clinical support from a specialist mental health pharmacist to review prescription charts and complete medicines related audits. The 2017/8 quarter one medicines management report showed that the Elmwood ward had met all the medicines management audit criteria.

Medications were stored appropriately in a securely lockable room within a locked cupboard. Stock levels of medication were audited on a weekly, monthly and quarterly basis. There were processes for the management of medication, which included prescribing, ordering, storage, administration and disposal. There was pharmacy support to each of the wards, which included advice on the use of medication and practical checking of medication and prescription charts.

The hospital had a procedure for the staged process for patients self-administrating their own medication, with decreasing levels of supervision from nursing staff. This was risk assessed based on patients' level of capacity and responsibility to taking medication. Some patients on the wards were at the stage of self administration where they attended the clinic room to collect and take their medication. Elmswood View had lockable medicine cabinets in each bedroom to allow for the final staged process of self-medication, where patients kept their own stocks of medication. At the time of the inspection, there were no patients assessed as being at this stage on Elmswood View.

Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. Safeguarding leads were identified within the service and there was a policy and procedure in place. Safeguarding alerts were recorded on the incident reporting system and any local alerts were discussed at the twice weekly safeguarding meetings. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

Patient records were held electronically with some paper records kept in a locked staff office. There was a whiteboard with key patient information to support staff having an overview of the patients in their care. As this contained patient identifiable information, the board folded to maintain confidentiality and ensure it was not visible to patients or visitors. Patient records were held securely in the staff office. Staff were aware of their responsibilities to keep patient information confidential.

Patients had access to a kitchen in the annexe to prepare their own food under staff supervision. We saw that the freezer used to store food was full of ice and required defrosting. The food in the fridge was not stored according to food hygiene good practice as uncooked meat was stored incorrectly above other food, opened food was not labelled with the date it was opened and there was a small number of out of date items in the freezer. Dried food in the cupboards was also not stored correctly as opened packets were not sealed and therefore at risk of contamination. Although there had been no incidents in the last 12 months relating to food hygiene issues, there was a risk of food poisoning because food was out of date and not stored correctly.

When we returned later in the inspection week, we saw that there had been significant improvements to the food storage in the annexed kitchen, the freezer had been defrosted and out of date food had been destroyed. There was a system in place for checking the food and posters placed on the fridge to support staff and patients to follow food hygiene processes.

Track record on safety

We looked at the incidents that had occurred recently at this hospital. All independent hospitals are required to submit notifications of incidents to the CQC. The hospital had notified the CQC of appropriate relevant events including safeguarding incidents and incidents which involved the police. Managers had taken appropriate action to manage these incidents.

Long stay/rehabilitation mental health wards for working age adults

Good

In the period May 2016 to April 2017, there was one serious incident recorded within the category, disruptive/ aggressive/violent behaviour which required investigation within the service.

All incidents were recorded on the electronic incident recording system. These were reviewed weekly and in the case of serious incidents also reviewed by the deputy hospital director and clinical nurse specialist. There was also a monthly risk meeting which as a sub group of the clinical governance committee reviewed all incidents and team incident reviews.

Reporting incidents and learning from when things go wrong

Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff were aware of the process for reporting incidents using the e-compliance system. Any lessons learnt were discussed at the ward meetings.

We saw that improvements had been made following a past serious incident on another ward in the hospital. On Elmswood View and House, the improvements had led to improvements in the availability of wire cutters and ligature knives to improve staff response if there was an incident of a patient tying a ligature. There had also been improved timeliness of clinical entry recording following a coroner's prevention of future death report relating to the same incident.

Duty of Candour

Staff told us that because of the low level of incidents and complaints, the threshold for the duty of candour was not often reached. There were organisational procedures to ensure obligations under duty of candour were recorded and met.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at eight care records. Staff used a recovery model to support patients' recovery. Care and support plans were developed from a recognised recovery based assessment tool (the mental health recovery star). This tool assessed and provided guidance on recovery based support to people with mental health needs. The mental health recovery star was a collaborative tool and allowed patients to set goals and map their own progress against these goals. We saw evidence that this assessment tool was being used by staff to plan care with patients.

All patients had received detailed assessment carried out prior to and after admission. Physical healthcare checks had been carried out by the medical and nursing staff on admission. Patients accessed physical healthcare and each patient had a separate physical health care record with evidence of on-going monitoring of health conditions. Care plans were in place to support people's physical healthcare needs such as asthma and diabetes. We saw that nurses could administer discretionary non-prescribed medicines for the symptomatic relief of minor ailments.

Care plans contained up to date, personalised, holistic, recovery focused information to support the treatment pathway. Care plans provided good information for patients and staff (including new staff) to fully understand what patients' strengths and needs were and how their needs were being met.

Patients also received individualised practical support to aid their recovery. For example, access to appropriate welfare benefits support, help with budgeting, and assistance with activities of daily living, such as shopping, cooking and cleaning. Patients were supported to access social, cultural and leisure activities, education and vocational resources to help aid their recovery.

Care plans and risk assessments were updated on an electronic records system while a paper patient file was also kept and available to all staff. There was a member of staff responsible for auditing records on a weekly basis to ensure accuracy.

Best practice in treatment and care

The ward followed best practice based on National Institute for Health and Care Excellence (NICE) guidance such as guidance on the treatment of schizophrenia. Patients received medical and clinical interventions to minimise symptoms of their mental health through both

medication and psychological interventions. Staff attended national networks and shared good practice. Discussions around NICE guidance and implementation within each of the services was cascaded via the team meetings.

Patients were able to discuss their medication at their weekly ward round. Patients commented that they were able to discuss and agree changes to their medication with their consultant psychiatrists who listened to them and acted on their concerns. When patients were prescribed high dose anti-psychotics this was monitored to ensure they did not experience strong side effects.

We saw that where needed therapeutic drug monitoring was carried out and recorded. Additionally, patients were supported to use formal side-effect rating tools for reporting and monitoring side effects in order that these could be managed effectively. Nurses had access to leaflets and further medicines information from an electronic pharmacy database to share with patients. This meant that staff could prescribe medication at a level that relieved patients' symptoms of mental ill health while ensuring that side effects were minimised'

Some patients had started to complete a 'my physical health check' plan which was a recognised tool formulated by the charity Rethink Mental Illness to improve physical health outcomes for people affected by mental illness in line with national CQUIN (Commissioning for Quality and Innovation) targets. However, this was not consistently used for all patients across the wards. Patients had access to physical healthcare, which included specialists when required. Patients were registered with an onsite GP. The occupational therapist was leading on looking at improvements in physical activity and impact on health through using the Kansas City cardiomyopathy questionnaire. This was a patient led recording tool that quantified heart and lung function symptoms (frequency, severity and recent change), social function, and quality of life. There were plans to review overall improvements in the scorings across the patient population over six months in December 2017.

Patients had access to psychological therapists. This meant that patients had access to talking therapy and other treatments to aid their recovery in line with best practice. This included cognitive behavioural therapy, and family therapy.

Staff regularly monitored and updated patients' progress using the recovery star. However, managers did not routinely monitor the overall effectiveness of patient rehabilitation and recovery progress such as formally reviewing the progress across all patients' recovery across the wards. The responsible clinician had plans to look at progress more formally following care programme approach meetings every six months to more fully evidence the wards' effectiveness.

Skilled staff to deliver care

The ward staff had access to a range of mental health disciplines which included nursing, psychiatry, psychology, occupational therapy, social work and secretarial and administration support.

We spoke with a number of staff including the clinical lead, healthcare assistants and the consultant psychiatrist. Staff were positive about their work and motivated to provide quality care and treatment. Staff were able to show they had expertise to support patients' recovery and address patients' complex and diverse needs including supervising patient medication regimes (including assessing and overseeing patient self-management), physical health promotion, psychological interventions, psychological interventions and therapies, self-care, everyday living and activities.

Staff told us that they had received supervision. The figures provided by the hospital showed a 91% compliance rate (against a target of 95%). Appraisal compliance rates were 100%.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input from medical staff, nurses, healthcare assistants and other professionals including an occupational therapist, psychologists and assistant psychologists. Patients were registered with the visiting GP for physical health assessment and on going checks. Staff could access other professionals for patients via referral through the GP, for example dietitian or speech and language therapy. There was full time domestic support to the wards.

Staff told us they worked together with other multidisciplinary staff to plan on going care and treatment

through the multidisciplinary team and handover structures which were in place. Care was co-ordinated from referral through to discharge or transition to another service.

Multidisciplinary team meetings were held once a week and used to manage referrals, risks, treatment and appropriate care pathways options. Any discharge planning was also managed via the multidisciplinary or care programme approach review meetings. Each patient was discussed at length and invited to attend their part of the meeting, and community mental health care coordinators were invited to care programme approach meetings.

Adherence to the MHA and the MHA Code of Practice

All staff had received training on the Mental Health Act 1983 and the Code of Practice. Staff received administrative advice and support from a central Mental Health Act administration team within the hospital. Staff told us they were contacted by this team to be reminded of deadlines such as informing patients' of their rights, consent to treatment or tribunal dates.

Overall, we found good evidence to demonstrate that the Mental Health Act was being complied with. The sample of Mental Health Act records that we reviewed were completed correctly, and copies were filed in each patient's records. Consent to treatment forms were attached to medication charts. Records showed that patients were regularly informed of their rights and were informed of the availability of the independent mental health advocacy service. Where patients received section 17 leave, the leave records contained clear conditions and parameters of leave.

Where patients were under a restriction order, the responsible clinician provided annual statutory reports to the Ministry of Justice. We saw that one patient had been awaiting approval from the Ministry of Justice for the next stage of their unescorted leave. We were assured that the responsible clinician regularly followed this up to progress the patient's recovery.

There was a clinical lead on the ward who audited all the patient files and compliance with the Mental Health Act. This included all aspects of the Act such as detention dates, consent and patient rights. This also audited staff entries and these were reviewed in supervision with qualified nurses.

Good practice in applying the MCA

The hospital had policies on the Mental Capacity Act and the Deprivation of Liberty Safeguards. The hospital provided training on the Mental Capacity Act, which was mandatory. Patients in the service were detained under the Mental Health Act. Any treatment decisions for mental disorder for these patients were therefore made under the legal framework of the Mental Health Act. We saw that patients' mental capacity to consent to their care and treatment had been assessed as required.

Staff understood the limitations of the Mental Health Act, for example staff knew that it could not be used for treatment decisions for physical health issues. However, records relating to capacity for treatment decisions were not always specific and did not always distinguish between physical and mental health treatment.

We saw examples of good capacity assessments and decisions made in line with the principles of the Mental Capacity Act. For example we saw one patient had been supported to refuse any future physical health intervention even though it could be regarded as an unwise decision if serious medical treatment was required.

The hospital had a best interest checklist form which covered the legal requirements when looking at best interests but we found that this was not used in all cases. This meant that where patients lacked capacity to consent to treatment for physical disorder, records were inconsistent in recording that the continuation of treatment was in the patients' best interests.

For example, two of the records we reviewed showed that the patients had been refusing oral medicines for a physical health complaint. The condition had resolved without treatment for one patient. However, the second patient was administered an injection when they refused their oral medication. The reasons for this were clearly recorded within their care plan but the best interests decision-making process did not fully follow the best interest checklist. We raised this with the consultant psychiatrist and the lead clinician and this was promptly addressed during the inspection with a multi-disciplinary record, fuller best interest consideration on the prescribed hospital form which included the patient's past wishes, checking any advance decisions and a much improved rationale for ongoing treatment. This meant that while

Long stay/rehabilitation mental health wards for working age adults

Good

there was evidence that staff understood capacity principles, they did not always fully record that best interest decisions were formulated utilising the best interest checklist.

There were no patients subject to the Deprivation of Liberty Safeguards at the time of our inspection. Staff were able to describe when the safeguards may be used.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

Staff were observed to have a caring attitude towards the patients on both wards. Activities and individual sessions went along as planned. It was clear that the staff on the wards were knowledgeable about the patients in their care and understood their needs.

We spoke with five patients who were all positive about the staff and their experience. They reported feeling safe on the ward and enjoyed the facilities available. They said the staff were caring, respectful and that they all were treated with respect and dignity. They all felt that the care they received was individualised and reflected how they could engage the wider community.

Staff told us they were particularly proud of the palliative care they had provided for two long term patients. Staff had worked in partnership with the local community nursing team to develop an end of life plan for these two patients involving relatives and managers in the hospital. Staff had undergone specialist end of life care training to meet the additional needs of the patients ensuring their wishes were met. Staff had also supported the family members to be present on the ward. It was obvious from talking to staff they had been determined to provide the best possible care within a familiar setting and that caring for these patients had had a profound affect upon them.

The involvement of people in the care they receive

There was an in depth pre admission process that ensured patients were orientated to the ward. Prior to admission patients were assessed and invited to visit to have a look around and meet some of the staff. Once admitted, patients were shown around and introduced to their key worker, other staff and patients on the ward.

Patients told us they were involved and encouraged to be part of their care and treatment decisions with support when it was needed. Patients attended ward rounds and care programme approach meetings so that patients had a say in their care and treatment. Patients were provided with copies of their care plans and it was recorded in the care records when a copy had been declined by the patient with an explanation.

Patients were involved in the running of the wards. Patients had regular community meetings where they contributed towards the management of the ward. Recent community meeting minutes showed that issues discussed included activities, the environment, food, patient suggestions and changes in the running of the hospital.

Staff confirmed that they had sufficient time to have weekly one to one meetings with patients for whom they were key workers.

Patients' rights to an independent mental health advocate were advertised within the ward in prominent places.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Staff carried out assessments of patients who were usually already in another hospital to consider the appropriateness of admission for rehabilitation to Elmswood House or Elmswood View. Staff liaised with other providers' staff to coordinate the transfer of patients from acute mental health wards and secure care, including transferring patients who were already detained under the Mental Health Act. The beds at Elmswood House and Elmswood View were spot purchased and paid for by local clinical commissioning groups for patients who were resident in their area. Most patients were from the Greater Manchester area or the wider North West region.

Long stay/rehabilitation mental health wards for working age adults

Good

Elmswood House had 11 beds and, at the time of the inspection, there were 10 patients. The average length of stay in the six months up until May 2017 was 1588 days which amounted to nearly 4.5 years. This was within the expected length of stay for patients with complex care needs as many of the patients at Elmswood View and Elmswood House had complex rehabilitation needs, had additional physical health needs and some had stepped down from forensic settings. Many of the patients required a longer term, complex care high dependency rehabilitation unit.

The population of the ward was static with only one patient discharged in the last 12 months. As patients had complex or treatment resistant mental illnesses, they were continuing to receive active treatment to facilitate their rehabilitation. The deputy ward manager told us that the introduction of Elmswood View, which was a step down facility from Elmswood House, created the opportunity to move patients on towards discharge. There were no episodes of delayed discharges for patients from Elmswood House or Elmswood View at the time of the inspection or in the previous six months.

Elmswood View had six beds but as the ward had only been open less than 12 months it was not possible to provide data on length of stay. The average occupancy in six months up to the inspection was 65%. However, the occupancy of the ward at the time of the inspection was higher and the staff told us the expectation was they would reach maximum occupancy in the near future.

We saw records of regular contact and communication with mental health professionals the local mental health NHS trusts, including invitations to attend regular care programme approach meetings. Staff at the hospital worked with other professionals to co-ordinate information and reports when people had hospital manager's hearings or mental health tribunals.

Each patient's care plan had information on discharge planning. Where patients were close to discharge, these plans were more detailed. For example, we saw one patient was being discharged back to their home area on a community treatment order. The discharge plans for this patient included regular contact with the community care co-ordinator and family as well as consideration of housing and finance needs. Discharge was considered at care programme approach meetings for all the patients.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment on each ward to support treatment and care. There was a large TV lounge, a dining area and a number of small lounges where patients could go to spend time alone or to meet with staff.

There was a separate building with a large activity room where music lessons took place, a pool table and a kitchen used for cooking sessions and formal cooking assessments. This was accessed via an outdoor area which was accessible from Elmswood House and from Elmswood View.

All patients at the time of our visit had their own mobile phones and could use these in the privacy of their own room if they wanted to make a private phone call. However, if patients did not have access to their own mobile phone there was also a fixed pay phone on the ward for patients to use.

Both wards had set meal times but all patients had their own cupboard in order to store their food. The kitchen was open at all times and patients could access this whenever they wanted to make a hot drink or snack.

Patients were able to personalise their bedrooms with photographs of family, items from home and posters. Patients all had their own key for their bedroom and could lock this when they were not using it, and patients told us they felt their possessions were safe on the ward.

Activities were available on each of the wards. The activities available varied; they included ward-based activities such as cooking, breakfast groups, music or crafts, and outdoor activities such as cycling, swimming and shopping trips. These activities were personalised with one patient enjoying escorted trips to a public house, while another requested a visit to a rock concert.

Patients had access to a designated multi-faith room in the main hospital building which was a short walk from Elmswood House and Elmswood View.

Meeting the needs of all people who use the service

During the tour around the ward we observed information was available for patients, carers and family members. Information was available on advocacy services for patients to access help and support.

Long stay/rehabilitation mental health wards for working age adults

Good

The ward manager advised us that interpreters were available if required so that patients, family members or carers could understand what care and treatment was provided.

We were also told how patients' cultural and religious requirements could be supported and this was confirmed when we spoke with patients. Patients told us how they attended local places of worship and dietary choices around religious beliefs were met. Care plans reflected patients' religious needs. Individual beliefs about treatment options based on faith were respected. For example one patient's care plan reflected their religious views on blood transfusions.

Listening to and learning from concerns and complaints

There was one formal complaint made about this service in the previous twelve months up to May 2017. Posters on the ward explained to patients and relatives how to complain if they were not happy with any aspect of the hospital.

The patients we spoke with told us they were given information about how to make a complaint. They also told us they were aware of how to access advocacy if they wanted to speak to someone who was independent about an issue. However, patients told us that the staff were approachable and that they would speak to them directly initially if they had a complaint.

Staff told us that they discussed any issues that come up from patients and learnt from informal concerns. This was done via the community meeting which was a forum to discuss and address informal concerns from patients. Minutes from community minutes confirmed that issues such as noise, behaviour and food had all been discussed in an open transparent way.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

The provider's visions and strategies for the services were clearly displayed in staff and ward settings and most staff could demonstrate they understood the vision and direction of the organisation. Staff were able to tell us about specific initiatives such as the five behaviours which were:

- putting people first
- being a family
- acting with integrity
- being positive
- striving for excellence.

Staff we spoke with were also able to discuss the division values which were:

- safety first
- valuing people
- your voice matters
- putting people at the centre and taking pride
- celebrating success.

Staff were able to tell us the names of the most senior people in the organisation. They had all met the hospital director and recounted when senior management had visited the ward. The staff felt that their immediate managers were approachable and easily contactable should they need to speak to them.

At ward level, all staff we spoke to told us that they felt supported by the clinical leadership team on the ward. They told us that they never felt worried to approach them and voice any concerns. They told us they felt listened to and their opinions were important. They felt they were encouraged to give their opinions in meetings and handovers about patient care and that these opinions were taken into account.

Good governance

There was a clear governance structure in place that supported the safe delivery of the service. One member of staff took on the role of the clinical governance lead and they conducted weekly audits of patients' records, sending out emails to the ward manager and individual staff outlining errors or omissions. Lines of communication from the senior managers to the frontline services were effective and staff were aware of key messages, initiatives and priorities of the service.

Long stay/rehabilitation mental health wards for working age adults

Good

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients.

Ward records confirmed that all fire and health and safety assessments were in order and up to date.

Leadership, morale and staff engagement

Sickness and absence rates across the hospital were low with a rate of 4% at April 2017. At the time of the inspection, the service had one member of staff on short term sickness and one member on long term sickness.

There were no ongoing bullying and harassment cases reported at the time leading up to our inspection. Staff told us they were aware of the whistleblowing policy and how to report this should they need to, they felt confident they could raise concerns to their managers if they had a problem. Staff felt they were listened to and that they would not fear victimisation if they spoke up.

Every staff member we spoke to told us they were happy in their job role. They reported that morale in the team was high and that they all supported each other. Staff told us they loved what they did. Staff felt they were empowered in their role to make decisions and this was supported by the clinical leadership team. Staff told us this was especially true when providing end of life services for two patients.

Senior ward managers told us that they had received leadership and mentorship training and reported this had helped them in carrying out their job. They felt empowered to make decisions to solve problems.

Commitment to quality improvement and innovation

There was a strong commitment to improving care with leadership shown to hold staff accountable through the clinical lead auditing role.

Staff were keen to innovate and told us they had done so with the end of life care project for two residents as well as the opening of Elmswood View as a step down ward which provided new pathways for patients, opportunities for staff to develop and implement new ideas.

The lead consultant psychiatrist had recently taken over clinical responsibility for Elmswood House and Elmswood View. They had intentions to use research to show patients' rehabilitation progress including better use of Health of the Nation Outcome Scale monitoring at care programme approach meetings.

The hospital did not formally participate in external quality initiatives such as the Royal College of Psychiatrists' peer review network which provided accreditation of rehabilitation services, or the Implementing Recovery through Organisational Change programme which was a programme for changing how the hospital runs to optimise meaningful recovery of people with mental health needs.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

All of the wards were clean, tidy and in a good state of repair. The ward layout did not allow staff to observe all parts of the ward. However, this was mitigated by the use of observations, thorough risk assessments and mirrors in some areas. Each ward had an individual environmental risk assessment which included ligature risk assessments and blind spot risk assessments. A ligature point is anything that patients could use to harm themselves by strangulation. The annual risk assessments identified any ligature points and actions for staff to reduce the associated risks. Staff reduced the risks by observations and being present in areas with higher risk, individual risk assessments and care plans.

Both Meadows and Orchard were mixed sex wards. The wards complied with guidance on mixed sex accommodation. This included en suite bedrooms and a separate female lounge area. Woodlands was a single sex ward for female only patients.

All wards had their own clinic room which was fully equipped, this included access to emergency equipment and emergency drugs that were checked regularly. Staff checked fridge temperatures daily and records were up to date. In each of the clinic rooms there was equipment such as weighing scales, blood pressure machines and, where required, an examination couch.

Each ward had access to seclusion facilities if required. The seclusion rooms met with requirements in the Mental Health Act Code of Practice. The seclusion room on Woodlands had been refurbished using a specialised material which became softer if people banged it. This had been installed after the ward had identified a higher number of patients being admitted who banged their heads as a form of self harm. The ward manager had presented a business case to the senior leadership team as to why they thought this type of wall would be beneficial for that specific ward. This was in keeping with least restrictive practice whereby patients who were engaging in this form of self harm could have a safe place to be nursed without causing harm to themselves and without the use of restraint.

The environment was cleaned daily and we saw cleaning records were up to date. Staff adhered to infection control procedures.

Staff wore alarms to call for help in an emergency. There were nurse call buttons in patient bedrooms and in communal areas. Staff were allocated to respond if an alarm was raised.

Safe staffing

At the time of our inspection the staffing establishment for each ward was as follow:

Establishment levels: qualified nurses (WTE)

- Meadows 11
- Orchard 14
- Woodlands 11

Establishment levels: nursing assistants (WTE)

- Meadows 45
- Orchard 30
- Woodlands 35

Good

Child and adolescent mental health wards

At the time of our inspection vacancies for each of the wards were as follows:

Number of vacancies: qualified nurses (WTE)

- Meadows 2.4
- Orchard 7
- Woodlands 0

Number of vacancies: nursing assistants (WTE)

- Meadows 5
- Orchard 8
- Woodlands 1

Number of shifts covered by bank or agency staff to cover sickness, absence or vacancies in the last three months

- Meadows 287 78 (365)
- Orchard 350 217 (567)
- Woodland 185 90 (275)

Number of shifts not covered by bank or agency staff to cover sickness, absence or vacancies in the last three months

- Meadows 0
- Orchard 2
- Woodland 0

Staff sickness rate in the last twelve months

- Meadows 4%
- Orchard 4%
- Woodland 4%

Staff turnover rate last twelve months

- Meadows
- Orchard
- Woodland

The hospital used a staffing model, which reflected the ratio of nurses to patients on the different services, in line with the wards own staffing establishment. These were adapted according to patient numbers and reflected the skill mix required according to patient need. A benchmarking exercise undertaken across Priory Healthcare in 2016 informed the staffing ladders, taking into account national recommended staffing models. These were then adapted to reflect the specific requirements of the hospital. The establishment calculator, which was based on the agreed staffing levels then informed the establishment required for safe staffing (the total number of both nursing and support worker posts required for the site). If the risks on the ward were high or if a patient required 1:1 nursing then additional staff were brought in above the staffing ladders.

Safe nursing levels for inpatient services were monitored using the electronic rostering system and the nursing tracker. The director of clinical services and ward managers reviewed staffing on a daily basis to ensure the complement of staff met the needs of the individuals on the ward. In addition, the senior nurse on duty and senior nurse on call system ensured that where staffing requirements change (e.g. through an increase to observation levels) or if staff are unexpectedly absent (e.g. have reported sick at short notice), staff were deployed to those areas to ensure continuing safety.

Medical cover for each ward was provided by a consultant psychiatrist. Speciality grade doctors were based on each ward during working hours. Outside of these hours, there was an on call rota and doctors would attend the ward when required.

Patients had one to one time planned in with the nurse that was allocated to their care. In between these times, all other staff were available for patients to talk to if they so wished. Staffing was sufficient to be able support patients to take leave from the wards.

The overall compliance rates for mandatory training for qualified and unqualified staff on the child and adolescent wards was above 75%.

Managers monitored the compliance rates electronically for their own ward. They were alerted when training was due to expire in order to book staff on in advance of this happening.

Assessing and managing risk to patients and staff

We looked at information provided by the hospital in relation to the use of seclusion and restraint. Restraint was used in the six months from November 2016 to the end of April 2017, on Meadows Ward 142 times on 20 different service users, on Orchard Ward 133 times on eighteen different service users, and on Woodlands 148 times on eleven different service users. None of these used prone restraint.

Seclusion was used in the six months from November 2016 to the end of April 2017, on Meadows Ward 104 times, on Orchard Ward 23 times and on Woodlands 29 times. There

were four episodes of long term segregation on Meadows Ward. We noted that figures for seclusion on Meadows Ward were similar to the levels of restraint. However, this did not mean that patients who were restrained were always taken to seclusion. There were some patients on Meadows Ward who had crisis care plans in place in which they had identified seclusion as the safest place for them when they felt like they may harm themselves or others. This was part of their plan of care rather than a restraint situation. Restraint figures related to 20 different service users where as seclusion related to significantly less patients. As Meadows Ward is a secure psychiatric intensive care unit this meant that the nature of patients illness on that ward were in the more acute phase compared to those patients on Woodlands for example, where they would remain for longer periods of intensive rehabilitation. Therefore, the higher levels of restraint and seclusion were in keeping with the type of ward. There had also been a recent increase in patients being admitted with drug induced psychosis, for those patients the effects were usually short lived but were characterised by extreme periods of violence and aggression, this was another reason noted for higher levels of seclusion and restraint but was usually for short periods until the effects of the substances wore off or appropriate medication was commenced.

We reviewed 19 care records as part of our inspection. Each patient had a complete and up to date risk assessment. Risk assessments were completed to a high standard and contained crisis plans which were individualised and included the patient views. Risk assessments were signed by the patients and where this was not possible for any reason, for example the patient was too unwell to participate this was clearly documented. This would be then revisited at a later date in order to try and engage the patient in their own risk management.

We found one blanket restriction on Meadows and Woodlands where the young people were not allowed their mobile phones. On Orchard Ward the young people were allowed mobile phones as long as they did not have cameras. This had been trialled at different times over the last two years but this had been very difficult to manage in terms of pictures of patients being posted onto social media thus causing safeguarding concerns. The Ward Managers individually risk assessed this depending on the patient group on the wards and all patients were allowed mobile phones when they went out on leave for safety reasons in order for them to be able to contact the ward if needed.

The patients on Woodlands and Meadows were always detained under the Mental Health Act. On Orchard ward this was not the case and there was appropriate signage on the ward to explain that informal patients can leave at will.

The hospital had an observation policy for observing patients. This ranged from hourly observations up to five minute observation. Staff were able to talk us through the observation policy and how this worked on their own ward. We found that during our inspection this policy was being adhered to. There was a search policy and this included guidance on how and when a patient should or could be searched. At the time of our inspection we did not see any patients being searched but we were able to see in patient records when this had happened that the policy had been followed. This included ensuring that a member of staff of the same sex was available to carry out the search.

We reviewed the use of restraint and found that this was always used as a last resort and that staff were skilled in de-escalation techniques. However, when interviewing patients we were told by two patients that they had experienced pain in their wrists when being restrained. We asked the hospital for more information about this including care plans for those patients, incident forms completed following incidents of restraint and evidence of referrals to safeguarding teams regarding these allegations. We were given assurances that the correct procedures were followed for those patients when these allegations were raised. However, we did have continuing concerns about the use of pain compliance in the form of wrists holds that was taught in the managing violence and aggression training across the Priory Group. We asked the hospital to cease the use of these wrist holds immediately and to seek out an alternative method us restraint which did not involve pain to patients. The hospital agreed to do this.

We reviewed the use of seclusion and found that all documentation was completed correctly and reviews took place within the correct timescales. We saw evidence that seclusion was used for the least time possible and was terminated at the earliest opportunity.

Staff we spoke with had a good knowledge of safeguarding and displayed a clear understanding of what would

constitute a safeguarding concern. Staff knew how to report a safeguarding concern and we saw that staff did this in a timely manner. Two of the three ward managers in the child and adolescent wards were safeguarding champions that staff could go to for advice around potential safeguarding concerns. Staff described good working relationships with safeguarding teams and reported they were responsive when concerns were reported.

A specialist mental health pharmacist visited the child and adolescent wards to review the prescription charts and complete monthly audits. The pharmacist recorded any queries and interventions regarding medicines on an electronic system. However, the most recent audit report (April to June 2017) recorded that the Orchard Wards had not acknowledged the majority of these due to IT (computer) access issues. This had been highlighted at the hospital's medicine management committee and action was being taken to try to bring about improvement. Nurses described how medicines incidents would be recorded electronically. We saw that in March 2017 one medicine incident had been recorded as serious, this was investigated in line with hospital policy. The pharmacist was not part of the ward rounds but nurses could access a range of medicines leaflets, including easy read, and discussed these with patients.

We looked at thirty-two prescription charts and associated authorities across the CAMHs wards. The prescription charts were up-to-date and clearly presented to show the treatment people had received. However, on Orchard Ward the doctors had not recorded the duration of treatment against antibiotic prescriptions for three patients. This is important to help ensure antibiotics are used effectively [NICE NG 15 Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use].

We looked at records for three patients who had been administered medication for rapid tranquilisation. We found inconsistency in recording these incidents on the electronic care notes system. On occasion, nurses made an entry in the nursing notes but no incident report was made. The clinical lead nurse told us that the under reporting of incidents had been identified by the ward and an action plan was in place, monitored by hospital managers. We checked ten post rapid tranquilisation physical health monitoring records. We could not find evidence of this monitoring on three occasions. Additionally, on two occasions all observations were recorded as refused, but the sedation score was not completed. It is important that these observations be completed to ensure patients' health and well-being.

We saw that where needed antipsychotic physical health and therapeutic drug monitoring was carried out and recorded. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines. We saw that concerns for example, about thyroid function or management of diabetes where discussed with the GP or specialists at the local acute hospital should the need arise. Patients were supported to monitor any medication-related side effects using the LUNSER tool (Liverpool University Neuroleptic Side-Effect Rating Scale) on Woodlands and Meadows wards. Nurses told us formal scales were not used on Orchards Wards but side-effects were discussed with patients at ward rounds, in order that appropriate action could be taken to manage these if patients felt they were a problem.

Medicines were securely stored and emergency medicines were regularly checked to ensure they were available if needed.

Visiting facilities were available for all three wards. These were situated off the main ward area so that visits could take place in a quiet setting. Risk assessments were carried out prior to visits and staff were present at visits if necessary.

Track record on safety

There were 71 serious incidents in the child and adolescent services in the 12 months leading up to our inspection, 53 of these related to incidents of violence and aggression.

The hospital had analysed the incidents of violence and aggression occurring on the child and adolescent wards. They had identified that a lack of planned activities in the evenings mirrored the higher number of incidents. While a comprehensive occupational therapy and educational programme was already in place, it only ran during the day Monday to Friday and there appeared to be a direct correlation between this and the frequency of incidents which showed a significant spike in the evening and on weekends. With this in mind a pilot scheme was initiated on Meadows whereby a dedicated activity co-ordinators were employed to work evenings and weekends.

Good

Child and adolescent mental health wards

There was a focus on recruitment and retention of staff which resulted in a marked decrease in the level of agency use. After 3 months, an analysis of the incidents was carried out and compared with the month prior to the commencement of the pilot. The analysis showed a marked change in the number and timing of the incidents. The number of incidents was shown to have significantly reduced, particularly at the times where spikes had previously occurred (particularly at weekends). This initiative has now been put into practice on Orchard Unit with an analysis of the incidents due to take place shortly. It should be noted that any incident that has the safeguarding section of the incident form completed is automatically logged as a 'serious' incident. So, for example, two patients having a verbally aggressive altercation are a safeguarding incident as well as an incident of aggression.

Reporting incidents and learning from when things go wrong

The hospital used an electronic incident reporting system, Staff we spoke with could identify a variety of incidents that would require reporting and were able to access and use the service's incident reporting system to do this. This included staff of all grades and professions from within the service. Ward managers had access to review the incidents reported on their ward and add any actions following the incident. Staff and patients told us that debrief happened following incidents and this was done at the earliest opportunity.

Staff were clear that they received feedback following incidents and this was communicated via staff meetings and one to one supervision. Incidents were also discussed in the handover which took place twice daily; staff were able to communicate incidents that had occurred to the next shift coming on duty.

On a weekly basis the previous week's incidents were reviewed to ascertain whether there has been an increase in any areas or types of incidents and, if there was, the reasons behind them. The incidents recorded as 'serious' on the system were also reviewed by the deputy hospital director and clinical nurse specialist and a team incident review assigned where necessary. Incidents were also discussed in the monthly Risk Meeting chaired by the hospital director and by the senior management team in the hospital governance meeting. If a team incident review was assigned it generated an action plan the status which was monitored by the deputy hospital director and was discussed in the monthly risk meeting. If a particular learning was something that may be of use to services other than that on which the incident occurred it was included in the hospital's risk bulletin or newsletter.

Duty of Candour

Duty of candour is a legal responsibility on hospitals to apologise and inform patients if there have been serious mistakes in their care and treatment that led to significant harm. This allows patients to receive a truthful account of failings in their care as well as a written apology.

All staff we spoke with had an understanding of duty of candour at a level appropriate to their role. Staff were able to give examples of what would trigger a response under duty of candour and how this would be dealt with.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Across the three child and adolescent wards we reviewed 18 care records. We found that all records contained a comprehensive and holistic assessment completed on admission. All records contained a physical health review that was completed on admission and updated on a regular basis. This included things such as weight management, diabetes monitoring and blood sample recording.

All care plans were holistic and, recovery orientated and individualised and had regularly been reviewed since admission; at a minimum of once a week or more frequently if the particular patient's care needs had changed. Patients had a variety of care plans that related to their individual needs. There were care plans for managing self-harm, safeguarding, seclusion and community leave.

All care plans were goal-orientated and recovery focused, We saw evidence of a good level of patient involvement and, if the patient agreed parent involvement. The "keeping well" care plans that each patient had identified what helped that particular patient feel well and what

could be done to help them when they weren't well. These were done in conjunction with the young person in order to allow them to identify what helps maintain their mental health at a level that is good for them.

The hospital used an electronic records system. Any paper records such as Mental Health Act paperwork were kept separately but were scanned in to the system at regular intervals. Staff consistently reported that they found the system easy to navigate so that they could access information in a timely manner.

Education on Meadows, Orchard and Woodlands was provided by Cheadle Royal School, part of the education division of Priory Group. The school was registered with Ofsted and underwent an inspection in October 2016. The outcome of this inspection was that all areas of the school were rated as good. The school had a development plan that took into account the improvement needed to work towards the school becoming outstanding.

Each patient's educational needs were taken into account during their admission. This included trying to engage with patients who may have been outside of the education system for some time or found it difficult to engage due to their mental health problems. This began with attempting to engage the young person in just one lesson per day or even one to one time with the teacher. The patient's home schools would be contacted to ensure that all the young people were working in line with their home school curriculum. This made it easier for the young person to integrate back into their home school after discharge.

Each ward had an allocated lead teacher and higher level teaching assistant who met with the young person to create an individual learning plan, a personalised timetable and discuss ways to support them in the classroom. Attendance, progress and engagement were monitored and reported back to the senior leadership within the school as well as the multi disciplinary team on each ward.

Progress was measured in two ways; the first being through subject specific data which was collected half termly and reported back to schools and colleges; and through a pupil progress profile which measured communication, both with other young people and adults, progress, engagement, hope for the future and concentration. These were measured at the start, half termly and at discharge.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence guidance when prescribing medication for patients. This included psychosis and schizophrenia in children and patients: recognition and management (CG155) and depression in children and patients: identification and management (CG28).

Each ward had a psychologist and an assistant psychologist. The therapies they offered included cognitive behavioural therapy, dialectical behavioural therapy and family therapy. This type of

psychological therapy is recommended by National Institute for Health and Care Excellence in guidance CG133; self-harm in over 8s and long-term-management. In addition to the group sessions, each patient was offered a one to one direct appointment per week as a minimum. The psychology team also held weekly formulation sessions on each ward where the staff team would all be invited to discuss a specific patient and look at how the team could do things differently to improve that patients care.

We saw evidence of access to physical healthcare when required. This included an on site dietitian and referrals to physiotherapists for patients with an eating disorder.

Staff used the Health of the Nation Outcome Scale for children and adolescents and the Children's Global Assessment Scale to assess and record symptom severity and monitor patient outcomes.

Staff participated in a number of audits on the wards. These included audits on medication cards, care plans and infection prevention and control measures. On all three wards, we found evidence that staff had completed the actions recommended from the audits completed. Staff told us that learning from audits were shared with staff through emails and team meetings.

Skilled staff to deliver care

There was a sufficient range of skilled staff delivering care to patients on the ward. This included nurses, doctors, activity workers, occupational therapists, education staff, social workers, psychologists, psychotherapists and dietitians. Staff were experienced and appropriately qualified to carry out their roles. Some nurses had achieved qualifications in psychosocial interventions. Children Act training was provided as part of the trust safeguarding training.

Good

Child and adolescent mental health wards

Data provided prior to our inspection showed that 100% of CAMHS inpatient staff had received an appraisal in the last 12 months. Records showed that staff had regular appraisals. The appraisal records were complete and comprehensive. The appraisal document included preparation for the member of staff, objectives, appraisee comments and appraiser comments.

At our last inspection we found that specialist training for staff looking after patients with autistic spectrum disorder was not available. At this inspection we found that this had improved. Fifty staff were trained by the National Autistic Society using the spell framework. There was also an e learning module available for staff on autism and positive behavioural support. The manager on Orchard ward was trained to diagnose autistic spectrum disorders. Other specialist training for staff included blood sample taking and electrocardiogram training.

Ward managers were clear they were able to address poor staff performance. We saw evidence of managers appropriately referring staff to occupational health and reviews being carried out by ward managers due to high levels of sickness. Ward managers would initially manage poor performance at ward level via informal action plans and increased supervision. Human resources staff supported ward managers when this process became formal, but they could ask for support and advice at any time.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings happened on each ward on a weekly basis. A number of different staff attended these including consultant psychiatrist, psychologist, service users, family members, nurses, occupational therapists and junior doctors.

Handovers took place twice daily at the beginning of each shift. All members of staff on duty attended the handover. Staff discussed risks, the level of observation, medication, patient presentation, education, leave, personal hygiene, diet, discharge planning and communication with relatives. Staff spoke positively about patients' progress during handover.

Staff had regular contact with community child and adolescent teams, social services and the local authority. We found evidence of communication relating to admission, treatment and discharge.

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

Mental Health Act Training was mandatory and compliance was at 85% at the time of our inspection. Staff we spoke to had a good understanding of the Mental Health Act and their responsibilities in relation to the Act.

We carried out a routine Mental Health Act monitoring visit two days before our comprehensive inspection. On that visit, we found good overall adherence to the Mental Health Act and Code of Practice.

During our inspection, we reviewed Mental Health Act documentation for 14 patients. We found that these were well maintained and up to date. There was a full set of detention papers on each file. There was good evidence of patients having their rights explained to them, this was recorded in the file and advocacy were involved in assisting with this when required. There was evidence of Mental Health Act tribunals taking place when required and records of discussions around and approval of section 17 leave.

There was a central Mental Health Act office where staff received support on the implementation of the Mental Health Act. Staff were aware of the support and told us they contacted the Mental Health Act office when needed. They sent out reminders to staff via email when tribunals were due, sections were due to expire and patients were due to be informed of their rights.

A weekly audit was completed by Mental Health Act administrator on site. The audit was shared directly with ward managers to take appropriate action. Each ward conducted a monthly audit to monitor compliance with the Mental Health Act and Mental Health Act Code of Practice. Compliance with the Mental Health Act was also audited via the documentation quality walk round. The pharmacist also conducted a monthly audit to monitor compliance with the Mental Health Act . Any issues arising from these audits were discussed during the hospital's monthly clinical governance meeting.

Where required, the relevant legal authorities for treatment were generally in place. However, compliance with the use of Section 62 (urgent treatment) was identified as an area for improvement at the hospital at the July clinical governance meeting. On Orchard (assessment) ward, we were similarly unable to find a section 62 for one patient. We also found that a patient on Woodlands ward recorded

as having capacity and consenting to treatment had an old T3 form with their prescription chart. The patient was not currently prescribed any psychotropic medicines, but we raised this with the nurses in order that it could be removed.

Independent Mental Health Advocacy services were provided by a local organisation, with information on how to access displayed on the noticeboard.

Good practice in applying the Mental Capacity Act

The Deprivation of Liberty safeguards does not apply to people under the age of 18 years. The Mental Capacity Act applies to young people aged 16 and 17. For children under the age of 16, decision-making ability is assessed through Gillick competency. This allows staff to recognise that some children may have a sufficient level of maturity to make some decisions themselves.

At the time of our inspection 76% of staff had training in Mental Capacity Act.

We spoke to staff and found they had a good understanding of the Mental Capacity Act. This included the presumption of capacity and decision specific requirements. Staff were aware that there was a policy on Mental Capacity Act located on the intranet. Staff told us they would seek advice from the multidisciplinary team and the Mental Health Act office.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

We spoke to eleven patients and seven parents of patients who were using the service during our inspection. They all told us that staff were respectful and polite when interacting with them. We heard comments such as "they are always approachable" "they listen to me" and "they respect my personal space". Parents likewise told us that staff were always available to speak to them when they visited and on the telephone. Some parent told us that they would like more contact with the wards but that they felt there was sufficient contact and updates following decisions about their relatives care. All patients we spoke to were positive about the education facilities at the hospital and felt they were positively encouraged to take part in classes.

During our inspection we observed interactions between staff and patients. We found all of these to be kind, respectful and staff took the time to respond to individual patients even during very busy times such as when staff were off the ward with patients on leave or when the medication round was ongoing. When patients were distressed, staff showed empathy and a range of de-escalation skills in order to help calm the patients down. There was a calm atmosphere on the wards which made it a more therapeutic setting for patients who were unwell.

When asked if they felt staff listened to what they say patients told us that they have weekly community meeting. We saw evidence of the "you say we did "boards up on the wards with changes made following patient suggestions for example, switching from a hot lunch to sandwiches at the request of patients.

The involvement of people in the care they receive

Patients told us that staff orientated them to the wards when they were admitted. Each ward had an information pack that was given to patients on admission which contained relevant information such as the ward telephone number, staff names and complaints procedure.

We reviewed eighteen care records for patients across the three wards and all of these showed that patients had been involved in them and that their views had been captured. Patients we spoke with told us they were involved in the formulation of the care plans and that they met with their named nurse once a week to review these together. Patients reviewed their individual risk assessment with their named nurse once a week or more regularly if needed. Risk assessments showed that staff considered patients' thoughts and that staff were mindful to take positive risks where appropriate to maximise patient independence. All patients we spoke with had a copy of their care plan or staff had documented where a patient had declined.

Patients attended the weekly multidisciplinary meeting to discuss their care with the staff team. Patients told us that they were consulted before the meeting as to what they

wanted to discuss. We were told that if patients didn't feel confident enough to go into the meeting or if they were too unwell then their thoughts would still be considered as the staff or their advocate would discuss them on their behalf.

Patients were involved in the recruitment process. Some patients told us that they had been asked to prepare questions for potential employees and that they were given feedback as to how they were answered to gain their opinions.

There was a well established advocacy service at the hospital and patients were able to tell us about their advocates and what their role was. They told us that advocates attended meetings with them if they wanted them to.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

The average bed occupancy over the three wards for the period 12 November 2016 to 11 May 2017 was as follows:

- Meadows 83%
- Orchard 83%
- Woodlands 98%

We found that beds were available for patients living in the locality when needed. However, due to a national shortage of inpatient child and adolescent beds for patients, there was an increased demand to admit eligible patients that could live in excess of 200 miles away from the hospital. Where patients had been granted authorised overnight leave, the service did not admit into leave beds, which meant that there was always a bed available upon return.

If patients became unwell there was a psychiatric intensive care unit on the hospital site (Meadows Ward) where patients could be moved to.

In the six months leading up to April 2017 there had been twelve delayed discharges on the three child and adolescent wards. The most were on Woodlands Ward (6). This was mainly due to awaiting an appropriate placement in the young person's local area. The South Region of NHS England specialised commissioning team developed a CQUIN to reduce average length of stays across specialised secure and CAMHS services. This was with a view to reduce the number of people placed outside of their home locality and away from the communities in which they usually reside. In response to this , Priory Healthcare issued the "reducing average length of stay strategy" document. The strategy identified causes of delayed discharge and outlined a plan of action to address these issues. There was weekly contact between service managers and NHS England to discuss patient progress and discharge plans. Discharge was always planned and therefore happened at an appropriate time of the day.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms at the hospital to support treatment and care. This included lounges, activity rooms, dining rooms, quiet lounges and bedrooms. All patients had their own ensuite bedroom. There were quiet rooms off the main ward area where patients could meet visitors. There was also an on site café where patients could go with their visitors if they had appropriate leave from the ward. Each ward had a telephone where patients could make a phone call in a private area. In the communal areas each ward had notice boards that displayed lots of information for example, advocacy agencies, complaints information and activities. There were also boards that contained photographs of events such as a prom which was held for the patient in hospital who could not attend their own prom. This gave the hospital a homely feel and the feeling that the staff and patients were a joint community rather than a hierarchical relationship.

Each ward had access to an outdoor area. However, none of the wards were on the ground floor so patients could not have free access to fresh air at all times. On Meadows ward this had been remedied by the creation of "the bridge" this was an outdoor area on the same level as the ward enclosed with a mesh so it was safe for patients. This had beanbags for patients to sit on and was often used for one to one time with staff and patients. The area was decorated with colourful walling material and gave a good view of aeroplanes passing over the hospital that some patients enjoyed watching.

Cheadle Royal Hospital was awarded a food hygiene rating of 5 (Very Good) by the local autourity on 21 June 2016. Patients were generally positive about the food that was

available to them. However, some patients complained that there was no hot options at lunchtime. This was something that had been discussed at community meetings and was recently changed as the patients on the ward at that time preferred a cold lunch. All ward managers reported that this was open for discussion and that the kitchen staff attended the community meetings on the wards to take feedback from patients.

Patients were encouraged to personalise their bedrooms and bedrooms that we saw had photographs and items from home that the patients had brought in with them. This also included artwork from groups they have joined and events on the wards. There was a locked space in each of the patients bedrooms where they could store any valuables.

During school term time there was an activity coordinator for each ward who worked from 4pm to 9pm Monday to Friday and 1pm until 9pm at weekends. This role was developed following a review of incident data that highlighted more incidents were occurring on the child and adolescent wards in the evenings and at weekends. During the school holidays which it was at the time of our inspection the activity coordinators worked also in core hours during the day. There was a range of activities on offer across the three wards these included, badminton, football, baking, milkshake making, expressive art group, boys and girls groups and creative writing group.

Meeting the needs of all people who use the service

All of the wards were accessible for people requiring disabled access by a lift, corridors were also wide enough to accommodate a wheelchair if required. On each ward there was an accessible bathroom with a wet room style shower.

There was a range of information on treatments, local services and how to complain on notice boards around the ward area. This included leaflets about medication and different mental health problems that patients could take and use if they wanted to. If leaflets were required in different formats or languages this could be done via the head office. There was also access to interpreters via a local interpreting services, bookable via telephone or online. Food was available via the on site kitchen to meet the needs of patients with specific dietary requirements such as diabetic, gluten free, vegetarian, vegan and halal.

There was access to spiritual support on all the wards via local religious leaders who were happy to visit patients. If patients were not well enough to go off the hospital site to attend a service there was an on site room that contained all religious texts required as well as a space for prayer.

Listening to and learning from concerns and complaints

There were 35 complaints received about the child and adolescent service in the twelve months leading up to our inspection, 21 of these were upheld and none were referred to the ombudsmen. Meadows ward had the most complaints with sixteen. There were no themes to note.

All patients we spoke to were clear that they knew how to complain. We saw lots of leaflets around the three wards detailing how to complain. Any lower level complaints could also be discussed at the ward community meetings if patients wished to.

There was a complaints policy dated March 2017 which details what action should be taken when a complaint is received. Staff we spoke to showed a good understanding of the complaints process appropriate to their role. All complaints were overseen by the senior leadership team and discussed at the clinical governance and senior management team meetings monthly. All managers had completed complaints handling for managers training and all staff complete complaints handling training, compliance for this was 86% at the time of our inspection.

Are child and adolescent mental health wards well-led?

Good

Vision and values

The vision or purpose for the hospital was

“Our purpose is to make a real and lasting difference for everyone we support”

The values or behaviours were

- Putting people first: We put the needs of our service users above all else.
- Being a family: We support our employees, our service users and their families when they need us most.

- Acting with integrity: We are honest, transparent and decent. We treat each other with respect.
- Being positive: We see the best in our service users and each other and we strive to get things done. We never give up and we learn from our mistakes.
- Striving for excellence: For over 140 years, we have been trusted by our service users with their care. We take this trust seriously and constantly strive to improve the services we provide

In order to embed the purpose and behaviours the Priory Group executive team visited each site in 2015 to present the purpose and values. Follow up visits took place in April 2016. All staff were invited to attend these roadshows. In addition to this a copy of the purpose and behaviours was sent to every employee in the company with their wage slip. Posters are displayed at the hospital and "credit cards" available for staff detailing the purpose and expected behaviours. Each ward manager was provided with copies of the executive presentation, which they used to present to new staff who may have missed out on the original visit. In addition the hospital director talked to all new starters about Priory's purpose and behaviours at the start of the induction course.

Staff we spoke to had a good understanding of the hospitals purpose and behaviours. They were integrated into the care certificate which was undertaken by all new support staff. Staff appraisals contained the behaviours, and during the process, the staff members selected the behaviours to focus on during the next 12 months and what actions were required and what support could be provided.

Staff all told us that the senior leadership team at the hospital were visible. Most of the senior team had worked in less senior roles within either the hospital or the wider priory group prior to gaining their current roles. Staff told us that they were able to contact the senior team via email and that they all had an open door policy when they were in their offices. Senior members of the team did quality walk rounds where they would visit the wards and give feedback to the ward managers. These are intended to be part of a supportive framework that encourages the maintenance of high standards and continuing quality improvement.

Good governance

The hospital had a clear governance structure with effective systems and procedures for overseeing all aspects of care. This included monthly clinical governance meetings which in turn fed into the divisional quality team and was presented to the divisional executive board on a monthly basis.

A sufficient number of suitably qualified and experienced staff covered shifts, and staff were able to dedicate a large amount of their time to face-to-face patient care. Staff participated in clinical audits and knew how to report incidents.

There was an organisation and local risk register in place. The register recorded high level risks to the organisation. The manager was able to submit items to the register. Local governance processes were of a high standard with lots of audits and actions to address any shortfalls identified.

There were good structures in place to monitor the Mental Health Act and Mental Capacity Act. There was a Mental Health Act administration team who were based at the hospital. They were able to prompt staff when anything to do with the Mental Health Act was due such as tribunal reports, rights and renewals.

The ward managers were all clear that they had sufficient authority to carry out their role. They all had the support of a ward administrator who was able to help them with any administrative duties.

Leadership, morale and staff engagement

Staff we spoke to during the inspection spoke positively about their roles. They told us they enjoyed their work and felt supported and valued in their roles. The team morale was high and staff appeared genuinely happy in their work. Staff told us they were empowered to bring their own ideas forward and that these were listened to and incorporated into the service.

The sickness rate across the three wards in the three months leading up to our inspection was 4%. We saw evidence in staff files of sickness being managed in line with the policy when people hit triggers for formal sickness reviews.

There were no cases of bullying or harassment at the time of our inspection. However, the provider had a whistleblowing policy and staff were aware of what this was and how to whistle blow if they wanted to. Staff we

spoke with were all clear that they could approach the managers at the hospital and raise concerns if they had them. They all felt their opinions were listened to and that they receive feedback in a timely manner.

The staff were given opportunities for development. For example, support workers could become lead or senior support workers that held extra roles to the other support staff. Qualified nurses were able to undertake their mentorship training to supervise student nurses. Staff had also completed training in how to take blood samples and electrocardiograms. Staff who were undertaking training were given time to complete their studies each month.

Staff were clear that the need to be open and transparent was important in maintaining the relationships they had with the patients. If something went wrong staff would apologise to patients and explain what had happened. There was a duty of candour policy that staff were aware of and knew how to locate it. Duty of candour is the need for staff to be open, transparent and to apologise when things go wrong.

Staff told us they knew the most senior managers at the hospital. They told us they were approachable and had an open door policy. Staff also told us they could contact the senior managers via email if they needed them and they were always quick to respond.

Commitment to quality improvement and innovation

Orchard ward had participated in the Royal College of Psychiatrists' accreditation for in-patient child and adolescent services (QNIC) and had received accreditation, demonstrating a commitment to quality and improvement. This was due to be reaccredited at the time of our inspection and had undergone its peer in March 2017, the report was in draft format at the time we inspected the service. There were no plans for the other two wards to be accredited.

Community-based mental health services for adults of working age

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community-based mental health services for adults of working age safe?

Safe and clean environment

The centre had been recently commissioned and the building completely refurbished from an existing building at the site of the hospital. The centre was a clean and pleasant environment and decorated to a high standard. Environmental and safety checks were undertaken regularly and cleaning records demonstrated a regular cleaning regime.

The centre had panic buttons available in all rooms. The risk from patients was described as low and there was low level acuity of the patients who accessed the service. Environmental assessment was undertaken and staff gave us examples of changes made to the environment to reduce risk.

All estates issues and repairs were included in the wider hospital estates calendar. Fire alarms, systems checks, electrical safety checks, and health and safety risk assessments were undertaken in line with hospital policy and practice. Major incident and contingency planning also formed part of the wider hospital practices and procedures.

The centre did not have a clinic room. Physical health monitoring was undertaken when required and the centre had weight, height and blood pressure monitoring equipment, these were maintained and calibrated in accordance with the manufacturer's instructions and included in the centre's environmental checks.

Support and help in an emergency was available from the hospital on call emergency medical alert systems. Emergency equipment was available from the hospital site and the wellbeing centre was included in the emergency policies and procedures of the whole site.

Safe staffing

The permanent staff team consisted of a centre manager, a medical secretary, a receptionist and three therapists who were employed one day a week at the Manchester Wellbeing Centre.

Sickness was at 2% with one member of staff leaving the service since opening in July 2016.

The service also had access to four employed therapists, seven sessional therapists and three medical consultants (two adult and one child and adolescent) as well as a consultant psychologist/clinical lead.

Administrative staff contacted patients and offered alternative appointments when staff were sick or absent. In the event of a crisis or long term sickness leave, re-allocation of patients took place following a review of their needs and availability of a therapist with the expertise to best meet their requirements.

Staff undertook a full induction and orientation to the service on commencement of their role. Mandatory staff training was on a rolling annual programme. Permanent staff who were employed by the service accessed mandatory training provided by the hospital. Training available included basic life support, breakaway training, safeguarding adults, and safeguarding children.

Assessing and managing risk to patients and staff

We reviewed 7 records relating to the care and treatment of patients, all of which contained a thorough initial assessment. This included a summary of presenting symptoms, patient history including previous therapeutic input, medical history and the assessment of presenting risk. Clinicians regularly reviewed and updated patient risk assessments. The risk assessment identified risks of suicide, self-harm, neglect and vulnerability to exploitation and made reference to either current or historical risk being

identified. Risk was reviewed at every contact with the clinicians and detailed in the progress notes in the patients' records. All the patient records we reviewed were for patients described as low risk.

Patient records indicated that risk was continually monitored and escalating risk was responded to appropriately. Staff identified the actions they would take in the event of any deterioration in a patient's wellbeing or in the event of increasing concerns about a patient's safety. Staff gave examples of responsive escalation of risk where patients were referred to external agencies or admitted as inpatients following initial risk assessment.

Established safeguarding procedures were in place at the hospital and permanent staff received safeguarding adult and child mandatory training. Staff were aware of their safeguarding responsibilities and described the hospital safeguarding procedures. Staff identified the safeguarding lead for the service and told us that advice and support was available if required. Staff followed the hospitals safeguarding reporting systems. Therapists that worked at the service on a sessional basis were responsible for ensuring they attended safeguarding training which was monitored by the wellbeing centre manager.

Lone working procedures were in place, no staff was left alone in the building and reception staff were always in the building. Help could be summoned from the staff on the wider hospital site and the centre was included in the emergency aid call response team's procedures.

Track record on safety

There had been one incident reported from this location since opening in July 2016. This related to a disclosure of self-harm during a therapy session, the patient attended the local emergency department for medical treatment.

Reporting incidents and learning from when things go wrong

All staff that we spoke with were aware of their responsibility to report incidents. An electronic system was in place and staff used the same system as the wider hospital site. Lessons learnt from incidents were an agenda item on the monthly team meetings. Permanent staff received safety bulletins via email which were shared nationally through the hospital group. These would be made available to sessional staff in the form a printed version. Incident information from across the service was cascaded to staff via the email bulletin system and discussed in monthly team meetings. Staff described incidents from across the service that had been instrumental in resulting changes made to practice.

The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers. Staff were aware of their duty of candour and had knowledge of the associated hospital policy. Staff were able to describe how they would respond to patients if things were to go wrong, and were knowledgeable of the hospital policy to support this process. The manager of the service informed us that there had not been a reason to initiate this procedure since the service was commissioned.

Are community-based mental health services for adults of working age effective?

(for example, treatment is effective)

Assessment of needs and planning of care

Treatment records demonstrated an initial and timely assessment of patients when they enter the service. Care planning was contained in progress notes and letters to GPs and other health care professionals. These demonstrated the ongoing assessment of patients' individual needs and subsequent actions taken.

Care planning followed a five step care pathway. On assessment the staff at the Wellbeing Centre would assign patients to services on this pathway, staff at the wellbeing centre delivered services to those on step two of this pathway. These were low intensity services which addressed problems such as mild/moderate depression, obsessive compulsive disorder, sleep issues, social anxiety and parenting.

Care planning was holistic and included the patient's physical health status. Care planning was individualised and a recovery oriented care planning approach was undertaken to address the issues raised. We saw examples of detailed assessment letters sent to the GP, and where medication had been prescribed this was clearly identified.

Information was stored securely in electronic format and was accessible to all staff. Information governance procedures guided staff to enable compliance against the law and assess whether information was handled correctly and protected from unauthorised access, loss, damage and destruction.

Best practice in treatment and care

The service delivered a range of psychological therapies recommended by the National Institute for Health and Care Excellence. These included one to one or group therapies and included approaches such as; guided self-help cognitive behavioural therapy, behavioural activation, structure physical activation, psycho education, self-help/ problem solving.

A range of standardised screening tools and outcome measures were used and we saw evidence within all care records that they were completed on a frequent basis. The centre used appropriate screening tools to help assess mood and anxiety. These were undertaken at the beginning, during and end of the therapy sessions to monitor how effective treatment had been in helping reduce anxiety or depression. For example, the patient health questionnaire PHQ-9 was used for screening, diagnosing, monitoring and measuring the severity of depression. The GAD-7, a self-reported questionnaire, was used for screening and measuring the severity of generalised anxiety disorder.

Prescribing practices were in line with national guidance and physical health assessments and monitoring was undertaken when required. Audits were undertaken as part of the wider hospital audit schedule.

Skilled staff to deliver care

All staff at the Wellbeing Centre were appropriately trained and skilled to deliver care. Therapists were appropriately qualified and had been trained in the range of therapies provided at the service. Experienced consultant psychiatrists assessed and treated patients who were using the service.

Staff professional registration was checked and monitored to ensure staff had been revalidated and demonstrate that they practiced safely and effectively. Registration and annual revalidation of the consultant psychiatrists who provided treatment at the service was up to date.

Disclosure barring service checks had been completed for permanent staff and psychologists and therapists working at the service on a sessional basis and using a practicing privileges contract were required to provide evidence of their professional indemnity insurance to the service.

Permanent staff received regular supervision and annual appraisal. Sessional therapists all arranged their own supervision, which was essential in order for them to maintain their professional accreditation. The records of this were checked by the service on a regular basis. All staff we spoke with were positive about the opportunities for learning and development.

Team meetings took place quarterly and it was a requirement that all staff attend three of these annually. Although on review of the meeting notes no clinicians had attended two of these meetings due to clinical commitments and that target could therefore not be met.

Permanent staff were required to undertake basic life support training, breakaway techniques, safeguarding adults and safeguarding children training. Sessional staff were required to undertake safeguarding training. Of the four permanent staff all had completed breakaway training; two had completed the safeguarding adults training. Basic life support training and safeguarding children training had yet to be completed and staff had been assigned dates for any outstanding training need.

The service had a staff performance and disciplinary policy in place to support optimum staff performance and address poor performance. Senior staff described supportive interventions for staff whose performance was poor ensuring every effort was made to optimise learning and development opportunities.

Multi-disciplinary and inter-agency team work

We noted effective working relationships with agencies external to the organisation, much of this communication being with the patient's primary care providers such as a GP and local authority.

There was good communication within the team, staff were able to refer patients to a psychiatrist if required and support was available within the team in multidisciplinary meetings to discuss treatment and therapist options for each patient.

Community-based mental health services for adults of working age

Staff told us that they could easily arrange in-patient admissions to the provider's hospitals when this was required.

Adherence to the MHA and the MHA Code of Practice

Patients using the service were not subject to the Mental Health Act, although all staff were trained in the Mental Health Act and had a good understanding of the same.

Good practice in applying the MCA

Mental capacity is the ability to make an informed (having appropriate information) decision based on understanding a given situation, the options available, and the consequences of the decision.

- The Mental Capacity Act 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The Mental Capacity Act is designed to protect and restore power to those vulnerable people who lack capacity.

Capacity was assumed for all patients and staff described assessment of capacity at each contact/ appointment. All the staff we spoke with had a good understanding of the Mental Capacity Act and the application of the act within their role. Staff told us that capacity issues rarely arose with the people who currently use the service. Staff described circumstances by which they may consider a patients capacity to make decisions and consent to treatment such as an intoxicated patient or people with cognitive issues.

Consideration had been made for the ability of young people under the age of 16 to give consent to treatment interventions and assess their ability to fully understand what was involved in the proposed intervention. The service had a policy in place to provide guidance to staff on assessing Gillick competency.

Patients had signed a consent form which explained how issues around patient information were managed and the treatment options available to them. Staff also explained the costs of treatment to people which was supported by written leaflets and internet information.

Are community-based mental health services for adults of working age caring?

Kindness, dignity, respect and support

Patients using the service told us that they were treated with kindness, dignity and respect. We observed that staff took time to communicate with patients in a respectful and compassionate manner, maintaining sensitive and supportive attitudes.

Patients told us that they were kept informed about their treatment and treatment options to enable them to make informed decisions about their care and treatment.

Systems for the recording and storage of patient notes ensured sensitive and confidential information was securely controlled. A confidentiality policy was in place and consent to sharing information agreement was in place. Patients' were aware of the confidentiality policy, the policy included reference to the Caldicott principles, and the limits of confidentiality.

The involvement of people in the care they receive

Staff described how they made sure patients were fully involved and informed throughout their treatment. Patients told us that treatment aims and goals were clearly explained to them. Patients and staff confirmed that objectives and outcomes were agreed before treatment commenced.

Patient feedback was sought on discharge. Information was available to patients detailing access to advocacy services. Patients were supported to access independent advocacy services if required.

Appointments were scheduled at the patient's convenience and the service was open to patients in the early evening to support working patients.

Are community-based mental health services for adults of working age responsive to people's needs?
(for example, to feedback?)

Access and discharge

Community-based mental health services for adults of working age

There was no waiting list at the centre. The appointment system was easy to use and patients were seen quickly, within seven days of referral or more quickly dependent on need.

The centre was open to patients from Monday to Friday. Patients told us that the service was flexible with their appointment times and were responsive to changes in their circumstances and appointments ran on time and were rarely cancelled.

Cancellation of appointments was not identified as an issue at the centre; the centre provided choice and ensured continuity of care and realistic alternative appointments would be made. Appointments ran on time and patients were kept informed of any disruption to their care and treatment.

The service did not collect 'did not attend' information although procedures were in place to contact the person's GP or other appropriate agencies if a patient's failure to attend an appointment raised concern. Staff were able to describe the steps taken to check on a patient's wellbeing if they did not attend a planned appointment.

The facilities promote recovery, comfort, dignity and confidentiality

The service consisted of a comfortable waiting area with reading material and refreshment available to patients. The building was decorated to a high standard, with good quality furnishings throughout. Although the waiting area was open and discussions with reception staff could be overheard.

There was a full range of rooms to support treatment and care. Interview rooms were also decorated to a high standard although the rooms were not sound proofed, there were plans in place to introduce white noise speakers which mask background noises.

A range of information leaflets were available to patients on treatment options, local services and how to make a complaint.

Meeting the needs of all people who use the service

The needs of different people were taken into account when planning the services such as age, gender, disability and those who were vulnerable or had complex needs.

Reasonable adjustments had been made to remove barriers for patients using the service. The service was able to access interpreters for patients whose first language was not English. The building had been adapted to ensure accessibility for disabled patients. This included flat surfaces and ramps for wheelchair users. The facilities and premises were appropriate for the services being delivered.

Listening to and learning from concerns and complaints

A complaints policy was available to provide guidance for staff in managing a complaint. There was an accessible complaints system and it was easy for patients to complain or raise a concern. Complaints were taken seriously and responded to in a timely manner; there was openness and transparency in how complaints were dealt with.

There were two complaints raised at the service since opening. Complaints were a standing agenda item at staff meetings to inform staff of issues raised by patients in order to improve the quality of services.

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Are community-based mental health services for adults of working age well-led?

Vision and values

The hospital had an identified vision which was 'to make a real and lasting difference for everyone we support'. This was underpinned by five behavioural values. These were:

- putting people first
- being a family
- acting with integrity
- being positive
- striving for excellence

The provider had also developed divisional values in conjunction with staff. These were:

- we put safety first
- we value our people
- your voice matters
- we put people we care for at the centre of everything we do
- we take pride in what we do.. and celebrate our success

Staff were able to describe the visions and values of the organisation and described how they implemented these

values into everyday practice. Staff told us that senior managers were visible in the service and visited regularly. Local senior managers were described as approachable and supportive by staff.

Good governance

There was an established governance structure with a defined hierarchy of reporting and decision making in the service. There were clear systems of accountability and senior managers were actively involved in the operational delivery of the service.

Processes were in place to manage and report performance. The provider's governance arrangements included checks which ensured consultant psychiatrists working at the service were appropriately qualified and competent. There were appropriate incident and complaint reporting systems in place which enabled learning. There were systems to ensure that staff complied with mandatory training and attended clinical supervision and annual appraisals. There was a system for staff and service user feedback which was encouraged and the information collated was acted upon.

National alerts/changes in practice, lessons learnt from serious incidents and best practice/national guidance was cascaded to the team with the use of email communication systems and staff supervision.

There was a system in place to identify, monitor and address risks at the service. The service held a risk register which included reference to appropriate issues such lone working, confidentiality and environmental issues and limited clinical information on first appointment with the service.

Leadership, morale and staff engagement

Staff spoke positively about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments. Staff were able to describe the governance arrangements that supported their roles. They were clear about the quality assurance and performance structures in place and how they would input and record data locally and externally. Staff described good support with supervision and peer review and opportunities to attend training.

Commitment to quality improvement and innovation

The service was committed to improving the services on offer and was looking at increasing accessibility of the service by: increasing service opening times, developing training sessions for GP's expanding its services for general wellbeing such as weight management, delivery of skin camouflage and providing services in local schools.

Good

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Good

Safe and clean environment

Both wards had recently undergone extensive refurbishment and were well maintained, clean, tidy and homely. Russell House is a two storey building and had some inherent difficulties in layout and observation. To mitigate these issues CCTV had recently been installed and mirrors were in place in difficult to observe areas. Risk management was in place which took into account the difficulties of observation in the environment. Cedar ward had two male patients and the ward complied with same sex accommodation guidance at the time of the inspection.

Six monthly ligature risk assessments were undertaken on both wards. Recent refurbishments have removed many potential ligature points in bedrooms and ensuite shower facilities. Furniture and fittings with a reduced ligature specification were also installed as part of this refurbishment. All patients admitted to the wards undergo a thorough assessment of risk which takes into account the ward environment and increased risks were managed using higher levels of patient observation.

Infection prevention and control procedures were available for staff reference and regular audits were in place to ensure adherence to these procedures. Cleaning schedules were in place and patients and carers described the environment as always being clean and tidy.

The wards had fully equipped clinic rooms and resuscitation equipment and emergency drugs were accessible in case of emergency. There was an established quality checking system to ensure stock balances and expiry date rotation. There was a schedule to check medical equipment for electrical testing and calibration. Fridge and room temperatures were checked daily. Staff were trained in infection control precautions including hand hygiene and sharps management. Hand washing facilities and antibacterial hand gel were available for staff use. The equipment and premises were cleaned in line with local policies and adequate personal and protective equipment was available to staff. Laboratory specimens were handled and stored in line with local policy and all staff were offered appropriate immunisation.

Environmental risk assessments were thorough, up to date and followed practice protocols. Staff had nurse call systems and CCTV covered all communal areas of the wards.

Safe staffing

The service uses an electronic rostering system and a staffing ladder model to determine the numbers and skills mix of staffing required for safe patient care and treatment. This establishment calculator was reviewed regularly and we were informed the staffing establishment on these wards had recently been increased. Other staffing requirements such as high observation levels were responded to by bringing in additional staff above the agreed compliment.

Cedar ward's staff establishment was 10.8 qualified nurses (WTE), 27 healthcare assistants of which 25 posts were filled with two vacancies. Bank and agency staff were taken from a regular pool of staff with experience of working on the ward. We were informed that agency staff were only used as a last resort and usually at night time. Staff worked long

day shifts with an minimum staffing level two registered nurses and four healthcare assistants on duty during the day, one registered nurse and three healthcare assistants on the nightshift.

Aspen ward staff establishment was 8.43 qualified nurses (WTE), and 18 health care assistants with 4 vacancies. The wards had two registered nurses and three healthcare assistants during the daytime and one registered nurse and two healthcare assistants at night time.

Staff from both wards and the wider hospital staff were able to cover for times of increased acuity and unexpected shortfalls in staffing levels. Managers were able to bring staff in if necessary to ensure there was a full complement of staff on duty. Patients told us that there was always enough staff on duty to receive one to one time with nurses and activities were rarely cancelled due to shortage of staff.

Both wards had the support of a full time dietitian and each ward was assigned a consultant psychiatrist. Speciality doctors were available to address patients physical health needs. An occupational therapist, family therapist and psychologist supported the therapeutic weekly activity programme. The wards had two physical healthcare nurses who covered the wards on a seven day rolling rota.

Assessing and managing risk to patients and staff

Planned admissions to the service underwent a pre admission assessment and admission was aimed at stabilisation and weight restoration. Risk assessment was holistic and mental and physical health was subject to monitoring and risk mitigation. Risk assessment was in place for all patients. Of the nine electronic records we reviewed risk assessments were in place which followed best practice in making decisions based on knowledge of the research evidence, the individual patient and their social context, knowledge of the patients own experience, and clinical judgement.

Positive risk management was evident in the risk management plans and risk management was conducted in collaboration with the patient. Risk management plans were recovery oriented and recognised the positive aspects of the patient's presentation and motivation to change. Multidisciplinary reviews were held weekly and risk assessment was discussed and changes made in response to ongoing and emerging risks.

Seclusion was not used on these two wards, there were no seclusion facilities in the building. Restraint was rarely used with the patients and only as a last resort for issues such as planned feeding. Rapid tranquilisation had not been used in the previous 12 months. Physical intervention training was adjusted to work with patients with eating disorders. Only low level holds were in use and aids such as neck cushions, which were introduced when restraint was necessary for nasogastric feeding to assist with the comfort of the patient. Physical restraint was constantly monitored and adjusted to each patient and one patient was described by staff as being instrumental in reducing the need for physical restraint with the use of a radio and comforting blanket which helped them overcome their resistance to nasogastric feeding.

There was a list of banned items on the wards which included items specifically for the eating disorder unit such as laxatives, chewing gum and food. Searches of patients followed local procedures and were initiated only for those where individual risks were assessed and care plans were in place.

The local safeguarding procedure provided guidance for staff on their responsibilities for the safety and wellbeing patients with particular responsibilities for those patients who are less able to protect themselves from harm, neglect or abuse. Systems were in place to ensure that adult and child safeguarding was fully integrated into local systems and practices and there was a designated room on Cedars ward and procedural guidance to facilitate child visiting on the wards. Staff were trained in safeguarding, there was a safeguarding lead within the service and an online referral system for safeguarding concerns. Weekly safeguarding meetings were held in the service.

Medicines were dispensed from and stored securely in the ward clinic rooms and stock rotation, transport and storage was in line with procedural guidance. Regular audits were in place and the pharmacist visited weekly. Medicine alerts were disseminated to staff and latest alerts could be found printed in a folder and on display in the clinic room areas.

Patients on these wards were particularly vulnerable to pressure sores and ulcers and pressure relieving mattresses were available for those patients requiring them.

Track record on safety

There had not been any serious incidents on either ward over the previous 12 month period. Staff were able to

explain the governance systems on sharing information of serious incidents across the service. Email alerts and team discussion about learning from serious incidents was evident in the service and staff described incidents were lessons had been learnt and practice changed such as the use of wire bound note pads and the potential for self-harm.

Reporting incidents and learning from when things go wrong

Incidents were recorded on an electronic reporting system. The majority of incidents on the eating disorder wards were absconding incidents, 25 incidents in the 12 months prior to inspection. Following analysis of the incidents the factors leading to these absconding incidents were factored into the refurbishment of the wards and a new key fob system was put in place. This has allowed staff to lock the external doors on the occasions a detained patient with a high risk of absconding was placed in the service.

All incidents were analysed by the staff team and lessons learnt captured on an electronically generated form. These were used to inform risk assessment, care planning and communicate any lessons learnt across the team. All incidents were reviewed weekly by the senior management team, trends noted and actions implemented if appropriate. Staff were supported through on going clinical supervision and weekly group sessions with a therapist, staff told us that debriefing was available to them after an incident.

Duty of candour

The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers.

Staff training included duty of candour which was also covered in the induction of staff to the service. A duty of candour policy was in place and all staff we spoke with were aware of the policy and were able to describe the steps necessary when something went wrong and when an apology was required. The ward managers informed us that there had not been a reason to initiate this procedure in the previous12 months.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Pre-admission assessment and on going assessment of need was evident within the care notes. Care planning included clear objectives and outcomes of the inpatient stay and was developed in collaboration with the patient, progress was regularly reviewed. Care planning was holistic, motivation based and recovery oriented. Discharge planning was evident in on going review.

Patients physical health and the physical effects of malnutrition or compensatory behaviours such as vomiting and the presence of mental health problems commonly associated with eating disorders (such as depression, self-harm, anxiety, substance misuse and obsessive compulsive disorders) were factors in the assessment process.

Assessment of physical health risks were identified on admission and regular physical health checks were made. The wards had designated physical health staff who undertook physical health checks. Staff were sensitive to the discussion of the patients weight and appearance and discussions on these areas were done in a compassionate and respectful way. Any physical and mental health comorbidities and the potential impact they may have had on each other were factored into the assessment of need and subsequent care planning process. All patients had access to a ward speciality doctor, GP located on site and access to the local hospital if required to ensure that their needs were appropriately met. There was 24 hours medical cover for any medical emergencies on site.

On going care planning review was evident to assess whether progress has been made towards objectives agreed at admission relating to medical stabilisation, treatment goals/outcomes and discharge progress.

Records were stored electronically and readily available to all staff, information governance systems ensured all information contained in these records were secure and available only to those involved in the patients care.

Good

Specialist eating disorder services

Education and information was available to patients and their families on the nature and risks of the eating disorder and the treatments benefits and limitations available to them.

Best practice in treatment and care

Treatment and care on Cedar and Aspen wards was based on the management of really sick patients with anorexia nervosa (MARSIPAN) guidance from the Royal College of Psychiatrists. This offers nationally recognised guidance on the best treatment and care for people with eating disorders. One of the ward consultants was actively involved in the development of this guidance and the on going national professional collaboration on these issues. Both ward consultants had specialised in working with eating disorder patients and had good professional network support for their roles.

Staff followed national guidance such as eating disorders: recognition and treatment, National Institute for Health and Care Excellence guideline. The service was responding to recent changes in the guidance on psychological treatment support published in May 2017 with plans to benchmark the service delivery in line with recommendations to use the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA). The National Institute for Health and Care Excellence has recommended MANTRA as a first line treatment for adults with anorexia nervosa. MANTRA is one of the newer treatments of anorexia and has been developed by the lead clinicians and researchers of the eating disorders service at the Maudsley Hospital in London. The treatment model addresses factors that are known to maintain anorexia in the individual.

The service used the standardised outcome measures: health of the nation outcome scales and eating disorder examination questionnaire. Outcome measures are used to objectively determine the baseline function of a patient at the beginning of treatment. Once treatment has commenced, the same instrument can be used to determine progress and treatment efficacy.

Physical healthcare planning was comprehensive and medical conditions such as bradycardia, hypotension and hypothermia which are common in people who are underweight were monitored as key markers of medical instability and risk.

Prescribing practices took account of national guidance, mental health and physical health conditions and the impact malnutrition and compensatory behaviours had on medication effectiveness and the risk of side effects.

Staff were involved in local audits such as environment risks, medication audits and care planning audits. The service had an annual audit plan in place. Action planning for audit activity was evident and issues raised from audit activity were reviewed in senior team meetings.

Skilled staff to deliver care

All new staff undertook a two week induction training programme. Staff training was delivered with an e-learning training package called foundations for growth. Mandatory face to face training included prevention and management of violence and aggression, basic/intermediate life support and safeguarding. The Priory academy monitored training compliance.

Senior team members had received train the trainers training in eating disorders accredited by Brighton University, and naso gastric tube insertion training and feeding. Training was cascaded to other team members. Support staff received training in meal coordination.

The service had a full time dietitian who was skilled in delivering patient-centred, individualised, holistic advice and support in nutritional restoration. Nutrition interventions are an essential part of treatment of an individual with an eating disorder. The dietitian supported individuals to restore regular eating patterns, achieve a healthy weight, and educate about food and appetite, as well as providing psycho-education to patients on the effects of starvation on the body. The dietitian supported staff in the essential skills of safe re-feeding of individuals at low weight, and in naso gastric feeding.

All staff had received annual appraisals and regular clinical supervision, all registered nurses were allocated supervisors and a weekly therapist led reflective practice group was also held to support staff. Annual appraisal rates were 100% complete by all staff, clinical supervision rates were 91% for the hospital with a target of 95% completion. All staff we spoke with told us that they received regular clinical supervision.

Mandatory training courses rates for the hospital included appraisal review at 100%, basic life support with defibrillation at 80%, breakaway 82%, confidentiality and

data protection 89%, cyber security 88%, Deprivation of Liberty safeguarding 88%, equality act 89%, fire safety 82%, handling complaints 96%, infection control 75%, introduction to health and safety 86%, IT security 89%, Mental Capacity Act 88%, moving and handling 84%, safe handling of medicines 86%, safeguarding children 90%, safeguarding vulnerable adults at 88% and the Mental Health Act at 85%.

Multi-disciplinary and inter-agency team work

The care programme approach was used to assess, plan, review and coordinate patient care where a formal review of care is made at least once a year.

A group of professionals met weekly in a multidisciplinary team meeting to discuss recommended treatment options and decisions relating to the care of individual patients. The multidisciplinary meetings were attended by the patient, consultant psychiatrist and occupational therapist. Other professionals would attend if required and staff described attendance by outside agencies such as community care coordinators particularly when discharge plans were in place.

There was evidence of good communication with local authorities, community mental health teams, social services and general practitioners and links with external agencies were encouraged and supported by the multidisciplinary teams. Families and carers were involved in the patients care and care planning where appropriate.

Advocacy services attended the wards regularly and all patients were aware of how to contact advocacy when they required support and representation at these meetings.

Individuals with eating disorders may present with a range of gastrointestinal manifestations and the wards had good links with gastroenterology services in the area.

Adherence to the MHA and the MHA Code of Practice

The service had a Mental Health Act administrator who had a lead role in maintaining processes and systems to support compliance with the Mental Health Act and the code of practice. The MHA administrator led on the day to day administration of the Mental Health Act and was in receipt of Mental Health Act documents to ensure they were legally correct and valid. They ensured that mental health section expiry dates were dealt with within statutory timeframes and coordinated hospital manager reviews and mental health tribunals. The administrator conducted regular audits of issues such as ensuring patients' rights under the Mental Health Act were communicated to the patient and recorded. They also gave advice to staff and patients if requested.

Section 17 leave was recorded in the patients notes which included the conditions of leave and escort requirements. Multidisciplinary assessment of risk was undertaken prior to leave being granted and recorded in the patient notes. Conditions of leave were clearly recorded and leave was reviewed regularly as part of the multidisciplinary review.

Staff we spoke with had a good understanding of the Mental Health Act and associated code of practice. Mental Health Act training was a mandatory requirement and all staff were up to date with this training.

Good practice in applying the MCA

The Mental Capacity Act 2005 requires health professionals to assess capacity, and determine best interests for an individual who lacks capacity to make a specific decision. A policy was in place to support staff when making decisions about the capacity of the patients in their care. Staff received training on the Mental Capacity Act and Deprivation of Liberty safeguards. Staff were able to describe the five leading principles of the act. Staff were able to describe situations where capacity would be assessed and how they would consider and implement capacity assessment and planning. Staff were aware of where to get advice about the Mental Capacity Act and Deprivation of Liberty and there were arrangements in place to monitor adherence to the Mental Capacity Act.

Patients' capacity would be assessed on admission with on going assessment throughout their stay. Patients described their involvement in decision making and care and treatment records also detailed how patients were supported to make their own decisions about their care. Patients were aware of independent advocacy support they could access to safeguard their interests, and how to contact them.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

Good

Specialist eating disorder services

We observed respectful interactions between staff and patients. Patients told us that on the whole staff were polite respectful and caring and were responsive to patients needs and some staff were described as fantastic. Health care assistants were said to be the main contact with patients as qualified nurses tended to be busy and spent a lot of time in the office. Domestic staff were also praised for their caring attitude and were very helpful to patients on the wards. Some patients had difficulty interacting with agency staff who have a tendency to work night shifts.

Staff understood the needs of the patients well and were prepared for their roles. Observations of communal interactions were positive and staff were professional in their approach to patients and their families. Patients felt that staff listened and understood their needs and some staff would go out of their way to ensure patients felt supported.

The involvement of people in the care they receive

Patients told us they were involved in care planning and understood that care planning and risk assessment process. Records showed that patients had been involved in the care planning process although not all patients told us they had received a copy of their care plans. Patient records were regularly audited in a patient quality walk round by the clinical quality team.

Patients told us that they had access to the multi-disciplinary team and were able to discuss their needs in meetings, therapy sessions and in one to one interactions with staff. Patients felt that staff explained emerging issues and treatment options to them well and were responsive to requests from patients.

A welcome leaflet was available to patients prior to and on admission, although patients told us that they did not feel as informed when discussing their orientation to the wards. Although they understood the restrictions placed on them within the treatment focus, they did not all feel fully prepared to this possibility prior to admission.

Carers were encouraged to be involved in the patients care where appropriate and felt confident in the support given to them. Links to the patients' wider social network were encouraged and supported by staff.

Patients are asked to complete a service user satisfaction survey on discharge. The results of these surveys are collated quarterly and action planning is put in place based on this feedback.

The service had a patient representative who championed the needs of patients, this representative visits wards and represents patient views at the clinical governance committee. They are also involved in the recruitment of staff and take questions pertinent to patients to the recruitment process.

Are specialist eating disorder services responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

A referral system was in place for admission to the service, referrals were accepted from a wide variety of public sector organisations throughout the United Kingdom these included NHS provider trusts, clinical commissioning groups, NHS England specialised mental health case managers, community mental health teams, psychiatric hospitals, acute hospitals. Referral meetings were held weekly. Cedar and Aspen wards were identified as having the longest waiting times for admissions as they were highly specialised services. Admissions to this service were planned and all patients assessed prior to admission.

The criteria for hospital admission for eating disorders treatment was for those who were aged 18 and above with a primary diagnosis of eating disorder. This may be too high risk, complex or persistent to be managed safely in a community setting. Patients are often admitted from out of area because of the specialist nature of the ward. There were two patients admitted from out of area on Aspen ward at the time of the inspection.

The average length of stay for patients discharged in the past 12 months was 87 days for Aspen ward and 142 days on Cedar ward. During this period bed occupancy at Aspen ward was 73% and Cedar ward 62%. Aspen had one

delayed discharge in the previous six months and two readmissions within 90 days of discharge. Cedar had no delayed discharges in this period and one readmission within 90 days of discharge.

The service has a reducing the average length of stay strategy which identified causes of delayed discharges with plans to reduce these delays. Delayed discharges were notified to NHS England specialist commissioning teams and clinical commissioning groups. The clinical quality team identified delayed discharges and attended referral meetings, each delayed discharge and action required would be highlighted to the commissioners by letter until discharge was complete.

The facilities promote recovery, comfort, dignity and confidentiality

Both wards had recently been refurbished with good quality finishes, colours and lighting. The physical environment was homely, personal and comfortable and promoted safety, privacy and dignity. All bedrooms were single occupancy with separate washing facilities. There were designated rooms for therapeutic activities and each ward had a separate clinic room for physical examination and care.

All patients had access to a telephone to make personal calls. Patients could use their own mobile phones although the signal for most mobile phone providers was weak within the building structure. Plans were in place to attempt to boost the signal. Secure storage of belongings was available to patients who required this.

Garden areas were accessible to all patients, these were pleasant outdoor spaces and Cedar ward garden had recently been refurbished. There were quiet areas and designated child friendly family room where patients could meet their families and other visitors.

There were designated areas where patients could make hot drinks and both wards had a large dining room where nursing staff working with the patients to underline the importance of clear eating rules for meals, and direct supervision of eating habits. Meals were prepared in the main kitchen and transported to the unit in heated trolleys. The eating disorders wards had a separate menu than the other wards at Cheadle Royal Hospital. The same chefs were assigned to the eating disorder wards to prepare the menu and promote consistency and approach. The dining tables were glass topped and the level of support and attention required was dependent on how much individual responsibility the patients could assume for their own food intake. A food hygiene rating of 5 (very good) was awarded to the hospital by the local authority in June 2016.

There was a full therapy program available to patients which included art therapy, nutrition education, mindfulness sessions, anxiety management, pamper sessions, films, escorted walks, understanding emotions sessions, yoga, pilates, dietetic group and dietetic discussion forum.

Quality environmental walk rounds identified environmental issues and actions identified to resolve these. Patient concerns and complaints relating to environmental issues were acted upon quickly through the complaints process and patients' identified and discussed environmental issues at regular speak up meetings within the ward community.

Meeting the needs of all people who use the service

The wards were able to respond to patients requiring disabled access. Ground floor areas would be utilised, bedrooms with larger doors and adapted ensuite facilities with lifting equipment were available to those who required them. The service had a lift to enable access to the second floor.

Information leaflets were available to all and could be provided in different languages if necessary. Interpretation services could be also accessed if required.

A multi faith room designed to facilitate personal prayer was for all to use and was equipped with resources such as a bible, rosary, prayer mat, prayer cards and holy books. Patients told us that their cultural and religious requirements were supported.

Support was available to carers and a patients and carers group was active in the service.

Listening to and learning from concerns and complaints

Patients and carers knew how to raise a concern and complaint with the service. Patients were informed about their rights to complain. Information was available to patients and carers detailing the procedural process including information about relevant external second stage complaints. The complaints procedure was described by

Good

Specialist eating disorder services

patients as easy to use and patients described staff support in the use of this procedure. Use of advocacy was encouraged and patients were aware of the support offered by advocacy.

Staff were able to describe the complaints process and associated governance structures. Complaints were a standing agenda item in team meetings and staff were able to demonstrate learning from complaints.

Complaints received by the service in the past 12 months were: Aspen ward, 4 complaints one of which was upheld. Cedars ward, 13 complaints 10 of which were upheld and one partially upheld. No complaints were referred to the ombudsman from either ward. There were 38 compliments received for both wards in the previous 12 months.

Complaints were seen by staff as an opportunity for patients to provide feedback about their care. Complaints received from patients and carers were continuously reviewed and acted upon to improve quality of care. A review of completed complaints about the service demonstrated clear reporting and quality improvement when responding to concerns and complaints. Patients described the response to complaints as being timely, addressing their concerns and demonstrating appropriate actions as a result of these concerns. Patients described the complaints process as effective and open and felt their concerns were handled respectfully within the process.

Concerns could also be raised and discussed in community meetings. On attendance at a community meeting it was noted that patients were able to discuss concerns directly with the whole community or through staff with the use of an anonymous reporting system. There was evidence of open and honest discussion and encouragement for patients to speak up and add to the discussions. All meetings were recorded and actions discussed.

Are specialist eating disorder services well-led?

Good

Vision and values

The hospital had an identified vision which was 'to make a real and lasting difference for everyone we support'. This was underpinned by five behavioural values. These were:

- putting people first
- being a family
- acting with integrity
- being positive
- striving for excellence

The provider had also developed divisional values in conjunction with staff. These were:

- we put safety first
- we value our people
- your voice matters
- we put people we care for at the centre of everything we do
- we take pride in what we do.. and celebrate our success

Road shows were held and promotional material displayed across the service to promote these visions and values. Staff at the service were able to describe the visions and values of the organisation and described how they implemented these values into everyday practice. Staff told us that senior managers were visible in the service and visited regularly. Local senior managers were described as approachable and supportive by staff.

Good governance

There was an established governance structure with a defined hierarchy of reporting and decision making. Senior managers were actively involved in the operational delivery of the service. Local quality performance indicators were collated on safety and quality and monitored by the divisional quality team monthly. Quality improvement objectives are set annually and progress monitored through the audit process.

Regular systems audits took place, organisation performance was reviewed and benchmarked against local and national outcome measures. The was an annual audit schedule which included ligature audits, reducing restrictive practice, information governance, restraints, infection control, schizophrenia, depression, safeguarding, risk assessments and observations, care planning, suicide prevention and clinical supervision.

Senior members of the team conducted regular patient, staff, quality and environment walk rounds. This was described as a supportive process of quality improvement

which ensures visibility of service leaders at ward level. Records of this process demonstrated quality dissemination of issues raised and action planning to ensure issues raised were addressed and followed up.

There were systems to ensure that staff complied with mandatory training and attended clinical supervision and annual appraisals. Systems were in place to monitor complaints and incidents across the service and these were investigated where appropriate. National alerts/changes in practice, lessons learnt from serious incidents and best practice/national guidance was cascaded to the teams with the use of email communication systems, supervision and continuing professional development sessions.

The service had a risk register in place, risk mitigation and action planning was reviewed monthly at the senior management team and clinical governance meetings.

Leadership, morale and staff engagement

Staff we spoke with talked positively about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments. Staff were able to describe the governance arrangements that supported their roles. They were clear about the quality assurance and performance structures in place and how they would input and record data locally and externally. Staff described good support with supervision and peer review and opportunities to attend training.

The views of staff were regularly sought and the hospital recognised the importance of collating and acting on the views of their staff. Where issues were identified, action plans were put in place to remove barriers to providing safe, quality care and improvements made. An employee engagement survey for 2017 detailed actions to develop listening groups with a 'your say forum' for staff representation. A local rewards and recognition scheme was also in development.

Information on patient experience was reported and reviewed alongside other performance data. Concerns were shared across teams and staff were aware what patients thought about their care and treatment. Following changes, feedback was sought from staff and patients to ensure that their experience improved.

Recruitment procedures included identity checks, employment history, professional registration and qualifications, right to work in the UK, health assessment, checks from the disclosure and barring service and reference checks.

Staff sickness was monitored. Action was taken where appropriate to support staff to attend work and flexible working arrangements were in place. There were no bullying and harassment cases on these wards at the time of the inspection. The service had a whistleblowing policy. All staff were aware of this policy and knew the mechanisms in place to report issues that arise.

Commitment to quality improvement and innovation

The ward manager had undertaken a tour of similar units to share best practice in the treatment and care of people with eating disorders. One of the consultants was actively networking best care and treatment in order to ensure best practice in comparison with other providers and professional bodies nationally and locally.

Aspen and Cedar wards have taken part and accredited by the quality network for eating disorders accreditation scheme in March 2017 (Royal College of Psychiatrists).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

On the acute wards for adults of working age, psychiatric intensive care units and children and adolescent mental health wards:

- The provider must ensure that the monitoring and recording of patients post rapid tranquilisation is in line with policy.

On the child and adolescent mental health wards:

- The provider must ensure that patients do not experience pain when subject to physical intervention.

Action the provider SHOULD take to improve

- The provider should ensure that best interest decisions are recorded in line with the provider's policy.
- The provider should ensure that staff receive appropriate training to help manage patients with personality disorders.
- The provider should ensure that patients receive debriefs following a period of seclusion and that this is recorded.
- The provider should ensure that the use of restraint and seclusion is reviewed to ensure that they are used appropriately

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Patients did not always receive appropriate monitoring of physical health following the administration of rapid tranquilisation This was in breach of Regulation 12 2 (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Patients were subject to painful holds during physical intervention. This was a breach of regulation 12 (1)