Good

Partnerships in Care Limited

Pelham Woods

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-129389252	Pelham Woods	Pelham Woods	RH4 2AD

This report describes our judgement of the quality of care provided within this core service by The Priory. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by The Priory and these are brought together to inform our overall judgement of The Priory.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

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

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

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

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

Summary of findings

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Overall summary

We rated Pelham Woods as good because:

- Both wards were safe and clean and received daily cleaning from domestic staff. Furnishings were well maintained and this included a recently renovated patient lounge area which was bright and welcoming. Convex mirrors had been installed in areas of the ward that had been identified as blind spots. Extra closed-circuit television cameras had been installed to cover areas of the garden which had been identified as difficult to observe continuously.
- The service had carried out significant work to identify restrictive practices on the wards and the reason they may have been in place. Those restrictions that were necessary to maintain the safety of the wards were kept under regular review. This meant that the breach in regulation identified in the previous report had now been addressed.
- The service had brought the staff and patients together to try to look at the way the wards were working and used the "Safewards" model which gives methods for reducing risk and coercion in inpatient wards. There were creative attempts to involve patients in all aspects of the service.
- Patients had care plans which were up to date, personalised, holistic and recovery focused. The multidisciplinary team actively involved patients and their families or carers in all aspects of their care and treatment during weekly reviews. Staff undertook comprehensive physical health assessments for all patients. Patients were having dental and optician appointments and regular blood pressure and weight checks.
- Patients had regular one-to-one time with staff and had access to groups such as walking, current affairs, gardening, goal setting and fitness with the support of technical instructors. They also provided recreational activities such as smoothie making and pampering sessions. Staff treated patients with dignity and respect and understood the needs of individual patients. Staff were proud of their work and the progress patients were making.
- Patients had clear discharge plans and progress towards discharge was discussed during handovers, multidisciplinary meetings and patients' reviews. There were no delayed discharges across the two wards.
- There were sufficient staff to ensure that patients received the right care for them at the right time. The service considered the fluctuating needs of the patient group and ensured that 'floating' staff could dedicate their time where it was most required. During the time leading up to the inspection, the service had recruited a number of permanent staff so reducing its reliance on agency and bank staff. Nearly all staff (98%) had completed statutory and mandatory training. Staff were receiving regular supervision and all staff had received an appraisal.
- The service demonstrated a commitment to achieving best practice and this was reflected in its performance and risk management systems and processes. Managers and staff worked in a systematic way to continually improve the quality of the services and to create an environment in which staff could provide high quality care. Managers reviewed governance arrangements in a proactive way to ensure that they reflected current best practice. The service was well led at ward level and by the hospital director with an inspiring shared purpose. The managers were striving to deliver and motivate staff to succeed with a great commitment towards continual improvement and innovation.
- Managers and staff took a systematic approach to working with other organisations to improve care outcomes.
- The staff were achieving consistently high levels of creative and constructive engagement with the patients, across all equality groups. Rigorous and constructive challenge from patients, the public and stakeholders was welcomed and seen as a vital way of holding the service to account.
- Staff knew how to handle complaints appropriately and there were different options available to patients should they choose to make a complaint either informally or formally.

Summary of findings

- There was clear learning from incidents which was fed back to the staff and the patients. Learning was fed back from the managers to the staff when things went well which promoted training, research and innovation. Staff were open and honest to patients and carers when something went wrong.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as good because:

- Both wards were safe and clean and were cleaned every day by the domestic staff. Furnishings were well maintained and this included a recently renovated patient lounge area which was bright and welcoming.
- Convex mirrors had been installed in the previously identified blind spot areas of the ward and in addition extra CCTV had been installed to cover previously areas of the garden which had been identified as difficult to continuously observe.
- An individual approach toward risk management was now in place.
- The service had carried out significant work to identify restrictive practices on the wards and the reason they may have been in place. Where restrictions were necessary to maintain the safety of the wards they were kept under regular review. This meant that the breach in regulation identified in the previous report had now been addressed.
- Although the service had been using high numbers of agency and bank staff there had been significant improvements in the time leading up to the inspection to increase the full time staffing numbers and to reduce the use of agency staff.
- Staff were having regular one-to-one time with patients.
- There were sufficient staff to ensure that patients received the right care for them at the right time. The service considered patients' fluctuating needs and ensured floating staff could dedicate their time where it was most required.
- Almost all staff (98%) had completed statutory and mandatory training.
- Learning from incidents took place during senior managers' meetings, shift handover, supervision, and reflective practice meetings and by email.

Are services effective?

Good

We rated effective as good because:

- There were comprehensive physical health assessment for all patients. Physical health assessments were monitored centrally for quality and completion by the quality team via a centrally monitored system.
- Patients were having appointments with the dentist and opticians, and had regular blood pressure and weight checks.

Summary of findings

- Patients had a copy of their care plans which were up to date, personalised, holistic and recovery focussed. The multidisciplinary team discussed care plans with patients weekly and updated them accordingly. The also carried out quarterly comprehensive care plan reviews.
- The occupational therapy team carried out interest-based screenings with patients and provided groups such as walking, current affairs, gardening, goal setting and fitness with the support of technical instructors. They also provided recreational activities such as smoothie making and pampering sessions and activities designed to develop the skills necessary to live independently such as budgeting and cooking.
- The service had brought the staff and patients together to try to look at the way the wards were working and used the "Safewards" model which gives methods for reducing risk and coercion in inpatient wards.
- Staff from the agency used had to be trained to the same standard expected of the permanent staff joining The Priory Group before they could work in the service.
- Staff were receiving regular supervision and all staff had received an appraisal.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with dignity and respect and understood the needs of individual patients
- Patients were invited to attend the monthly clinical governance meeting and actively engaged with the service to improve the quality of the patient experience.
- The multidisciplinary team actively involved patients and their families or carers in all aspects of their care and treatment during weekly reviews.
- There was a regular direct link form the ward to the senior management of the service through the weekly patient forum meeting which gave all the patients the opportunity to have direct input into the running of the service. The meeting was attended by the patients plus the consultant and the hospital director.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- Patients had clear discharge plans and progress towards discharge was discussed during handovers, multidisciplinary meetings and patients' reviews. There were no delayed discharges across the two wards.
- The communal garden areas of the ward were well maintained and the doors to the garden were open permanently open. Therefore, patients could access fresh air and had an opportunity to go into the garden whenever they wanted without restriction.
- The ward had computers available in the communal areas for all patients to use.
- Patients could access interpreter services and the kitchen was able to make culturally appropriate food if required to meet the needs of the patient group.
- Staff knew how to handle complaints appropriately and there were different options available to patients should they choose to make a complaint either informally or formally. The community meeting was used to discuss informal complaints. However, they were aware that patients should be advised to write to the hospital manager if the complaint could not be managed informally.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- Governance arrangements were proactively reviewed and reflected best practice. There was a structured governance based approach to continually improve the quality of its services and an environment in which staff could provide high quality care.
- The service demonstrated commitment to best practice performance and risk management systems and processes
- The staff were achieving consistently high levels of creative and constructive engagement with the patients, across all equality groups. Managers and staff welcomed rigorous and constructive challenge patients, the public and stakeholders and this was seen as a vital way of holding the service to account.
- The service was well led at ward level and by the hospital director with an inspiring shared purpose. Staff were striving to deliver and motivate staff to succeed with a great commitment towards continual improvement and innovation. Staff were proud of their work and the progress patients were making.
- The service was responsive to feedback from patients, staff and external agencies. They had been proactive in capturing and

Summary of findings

responding to patients' concerns and complaints with clear learning from incidents which was fed back to the staff and the patients. Also, there was a system to learn when things went well which promoted training, research and innovation.

- Comprehensive and successful leadership and clinical strategies had been put in place to ensure clinical delivery and to develop and improve the culture of inclusion within the service across all equality groups
- Staff were open and honest to patients and carers when something went wrong. We saw this reflected in the complaints and incidents we reviewed.

Summary of findings

Information about the service

Pelham Woods hospital is an independent hospital owned by the Priory Group, an independent organisation that has a number of specialist hospitals spread across England. The Priory Group purchased the hospital from the former owners, Partnerships in Care, in 2017.

The Priory Group provide care and rehabilitation through recovery and treatment centres for people with learning disabilities, physical disabilities, mental health problems, substance misuse issues, complex care, autism, dementia and young people in transition.

Pelham Woods is a purpose-built facility that opened eight years ago. It provides care and treatment for women who have complex mental health problems and a history of challenging behaviour. The service is a High Dependency Rehabilitation unit. The service treats patients with a diagnosis of personality disorder, mental illness or mild learning disability, substance misuse problems, a history of trauma or offending behaviour or a combination of these difficulties. Some patients are detained under the Mental Health Act 1983.

The hospital has two wards, Elyn Saks ward has 18 beds each with an ensuite shower and toilet. Rosa Parks ward is a three-bedroom step-down flat with kitchen, communal bathroom and toilet.

The hospital is in a residential area of Dorking, Surrey.

Pelham Woods hospital has been registered with the CQC since 29 December 2010.

There have been five CQC inspections carried out at Pelham Woods. The most

recent inspection took place on 25 April 2016 when the service was found to be good. At our last inspection, Pelham Woods was found to have two breaches of the Health and Social Care Act 2008 and two requirement notices were issued.

A requirement notice is issued by CQC when an inspection identifies that the provider is not meeting essential standards of quality and safety. The provider must send CQC a report that says what action they are going to take to make the required improvements to meet the regulations.

Regulation 12 Safe care and treatment

The provider did not ensure that care and treatment was provided in a safe way for service users.

The ligature risk caused by the patients' bedrooms had not been fully assessed or mitigated.

Regulation 10 Dignity and respect

The provider did not support autonomy, independence and involvement in the community of the service users.

Blanket restrictions were in place which were not in response to current recorded patient risk. Patients could not use mobile telephones with internet access or cameras and patients had restricted access to the internet. There were rooms that patients could not freely access such as the toilets in the main ward area. There was no free access to outside space.

On this inspection (October 2018) the provider had made all the improvements required.

Pelham Woods is registered to carry out the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment or disease, disorder or injury.

A registered manager was in place at the time of our inspection.

Our inspection team

The team comprised two CQC inspectors and three specialist advisors with experience of working in long stay mental health in-patient settings.

Summary of findings

Why we carried out this inspection

We inspected this service as part of our ongoing 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, asked a range of other organisations for information

During the inspection visit, the inspection team:

- visited two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with seven patients who were using the service;
- spoke with the hospital director and the ward manager;
- spoke with 10 other staff members; including doctor, nurses, occupational therapist, psychologist
- attended and observed one hand-over meetings, one nurses team meeting;
- collected feedback from 15 patients using comment cards;
- looked at five care and treatment records of patients:
- carried out a specific check of the medication management across the wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with seven patients during our inspection who were all happy with their care and the treatment the service provided.

Patients identified that the staff team were committed to supporting their recovery and rehabilitation. They had copies of their plan of care and felt they had been involved in developing their plan.

Patients felt safe on the wards and that their possessions were kept safe.

Patients noted that the service had significantly improved in the year the current hospital director and the month the current ward manager had been in post and they now felt much more involved in decisions about the service and felt their concerns were taken seriously and could tell us of improvements that had been made because of their input.

Good practice

Care and treatment was done in collaborative partnership with the patient, families and external agencies ensuring that patients were involved in all the decision-making processes and developments within the hospital. In addition, the integration of the Safewards approach had empowered the staff and the patients to work together to create service specific plans which reduced flashpoints of behaviour and increased respectful interactions.

Partnerships in Care Limited

Pelham Woods

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Pelham Woods	Pelham Woods

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 provided training in the Mental Health Act (MHA) and 95% of staff had completed this. Staff members had a good working knowledge of the MHA.
- Mental Health Act documentation to identify whether a detained patient had consented to treatment or not or lacked capacity to consent to treatment were available and completed correctly. They were kept in patients' care records and attached to their medicine charts. It was evident that regular audits to ensure MHA documentation and compliance were undertaken.
- Staff reminded patients of their rights in line with the provider's policy and the MHA Code of Practice. This was clearly documented within corresponding care plans.
- The service had access to an independent mental health advocate (IMHA) and their contact details were displayed on both wards. All detained patients were automatically referred to them. The IMHA visited the ward weekly and was currently supporting a number of patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff were trained in the use of the Mental Capacity Act (MCA) and were aware of the need for capacity assessments to be made dependent on the decision to be made. There were no patients who required deprivation of liberty safeguards applications at the time of the inspection.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Both wards consisted of corridors containing patients' bedrooms, With a kitchen, dining room and day room adjacent to each other. Staff had a clear view of both corridors and dining room from the area outside the nursing office. Staff were consistently walking around the ward and checking on patients' whereabouts. We saw that convex mirrors had been installed in the previously identified blind spot areas of the ward and in addition extra CCTV had been installed to cover areas of the garden which had previously been identified as difficult to continuously observe.
- The main ward had a fully equipped clinic room that was clean and tidy. Staff recorded temperatures of medicine fridges daily to ensure they were safe for use. The ward had an emergency medicines bag that was checked regularly by an external pharmacist. We found the wards had shared access to the defibrillator and electronic weighing scales.
- Clinic room audits were completed and the emergency resuscitation equipment was checked regularly and in line with the organisation's policy. Records showed completion of daily and weekly checks such as: the clinic room, infection control, environment, medicines management and controlled drugs prescriptions.
- The unit was an all-female unit. All rooms had ensuite facilities.
- All staff and visitors had access to personal alarms to enable them to summon support if required. The service had nurse call alarms in all patients' bedrooms and communal areas. If the alarm was activated, a panel next to the nursing office on the ward displayed the area of concern. The organisation was in the process of reviewing the alarm system which, although it was adequate, showed that the organisation was committed to improving the safety systems on the ward
- Domestic staff carried out daily cleaning of the patients' kitchen area. We checked fridges and found food was stored safely. All opened food was sealed appropriately and contained a sticker to identify when it was opened and expiry date. Staff regularly checked and recorded temperatures of fridges and freezers used to store patients' food. The service manager audited these and carried out regular spot checks to ensure they were accurate.
- Both wards were clean and received daily cleaning from domestic staff. Furnishings were well maintained and this included a recently renovated patient lounge area which was bright and welcoming.
- Patients had access to their own bedrooms dependent on individual risk assessments. Bedrooms had ligature points such as electric wires from televisions, radios and laptops. We could see that each patient had an individualised risk assessment which identified their own personal risks and the risks that were identified in their immediate environment. This meant that an individual approach toward risk management was now in place and the previous breach of regulations had been fully addressed.
- At every handover, staff carried out regular environmental risk assessments of the building and garden areas that identified potential risks and plans in place to reduce these risks.
- The garden area was freely open to all patients throughout the day and night allowing them to have access to a safe open space. Patients told us they appreciated this change because previously the doors had been locked and the garden had been opened as and when required. This was evidence of increased consideration of reducing restrictive practices across the wards.

Safe staffing

- The service employed nine registered mental health nurses, with three vacancies, and 12 nursing assistants, with two vacancies. The other multi-disciplinary members were a full-time locum consultant psychiatrist, a part-time (30 hours per week) clinical psychologist, a full-time occupational therapist (OT) a full-time OT assistant, a part time (15 hours per week) art psychotherapist, a part time (7.5 hours a week) drama therapist and a part time (22.5 hours per week) peer support worker.

Good

Are services safe?

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- The unit had one locum consultant who worked full time. The established consultant position had already been recruited to and the new consultant was due to start in January 2019.
- Patients were very positive about the input from the locum consultant and were all able to name him and describe his input into their care.
- There were no junior doctors. Medical cover was provided by an on-call consultant from Priory Hospital Burgess Hill, which was 28 miles away. Therefore, the unit was encouraged to use emergency services for physical health problems or injuries rather than call the on-call doctor due to the distance to be travelled. The on-call doctor was available by telephone for advice for mental health issues and would attend the unit if required.
- Between 1 May 2018 and 31 July 2018, the service used bank staff to fill 110 shifts and agency staff to fill 356 shifts. The service had six shifts unfilled during this period. The high use of agency staffing had been regularly highlighted on the organisational risk register and discussed in the governance meetings. The service maintained safe nurse staffing, despite the hospital's recruitment challenges.
- The service had made significant improvements in the time leading up to the inspection by employing new staff and increasing the full time staffing numbers which reduced the use of agency. The service had attended local recruitment events and universities to promote the service and had sought appropriate social media groups to promote the recruitment opportunities. We saw evidence to show there were a number of staff going through pre-employment checks due to start in the weeks following the inspection. This meant that the service had acted to significantly reduce the amount of agency and bank staff.
- The hospital manager could use additional staff if required. They gave examples of extra staff being used to take patients on leave or to hospital appointments. An example was also given of extra staff being used to support a patient who had been on increased observation levels.
- Staff told us they could have regular one-to-one time with patients. This often happened in the afternoon or at weekends. Patients confirmed that staff were available for them when they needed.
- Staff told us that escorted leave was never cancelled. If it was delayed patients were made aware of this. If patients required leave that involved staff escorting them long distances, this was prearranged and extra staff used if needed. Ward activities and therapeutic groups were rarely cancelled apart from when attendance levels were low.
- Staff received mandatory training in 31 areas relevant to their roles. These included safeguarding adults and children; the Mental Health Act; the Mental Capacity Act; management of aggression; emergency procedures awareness; managing challenging behaviour; positive behaviour support and intermediate life support. The overall staff completion rate across all required training was 98%.
- Families could access a family and children's visiting room situated off the reception area of the service.

Assessing and managing risk to patients and staff

- Between 1 February 2018 and 31 July 2018 there had been no incidents of seclusion or long-term segregation at the service. There had been 36 reported incidents of restraint involving six patients. Physical restraint was monitored monthly through clinical governance with clear accounts being made for its use. This included the level and duration that restraint had been used. The site had minimal use of rapid tranquilisation. On site trainers reviewed all incidents of restraint to ensure they met standards and that levels of restraint used were proportionate to the incident reported.
- We reviewed five patients' care records and all contained an up-to-date risk assessment. The service used the Priory group "five Ps" risk assessment. The "five Ps" model involves identifying presenting risks, predisposing, precipitating (triggering), perpetuating, and protective factors, and developing a narrative to describe factors likely to increase and factors likely to decrease risk behaviours. This then informs the clinical team's decisions regarding the appropriate course of action to take.
- The service also used the historical, clinical risk assessment tool (HCR20), a tool predicting a patient's probability of violence.
- Risk management plans were present which identified specific groups and interventions the service was offering to patients. We saw these coincided with patients' care plans. Risk assessments were all regularly reviewed by the ward doctor, and the multidisciplinary team (MDT) in monthly clinical meetings.

Good

Are services safe?

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- The service restricted patients from using some items such as lighters, toiletries and phone chargers. These items were collected after use and kept in lockers in the nursing office. However, patients did not have restrictions on the times they could use these items. The service explained this process to all patients on admission. In addition to this the service had made significant steps in reducing restrictive practices with the service holding a quarterly reducing restrictive practices forum attended by the MDT and a representative from the patient council. There was also a file available in the office identifying restrictive practices on the wards and the reason they were in place, it was clear that where they were necessary to maintain the safety of the wards they were kept under regular review. This meant that the breach in regulation identified in the previous report had now been addressed.
- The service was implementing the Safewards initiative to assist with the reduction of violence and aggression. Both staff and patients had been involved in this process with joint groups held to develop mutual expectations. The service had implemented half of the interventions required at the time of the inspection and had plans to complete the Safewards programme.
- Although the ward was locked, the informal patients were aware they could ask a member of staff to leave the ward at any time. The ward had clear signage by the entrance door which explained this clearly. Staff told us they would carry out a risk assessment before allowing informal patients to leave the ward.
- Staff carried out regular observations and recorded the whereabouts of patients during the day. The service had appropriate policies to allow them to increase observation levels if risks were identified. Staff searched patients returning from unescorted leave to ensure they were not bringing contraband items, such as lighters, on the ward. This was clearly identified in the entrance lobby and patients told us this was explained to them when they came to the service.
- The service carried out regular ligature audits with associated action plans, this was last competed in July 2018. In addition to this all staff joining the service completed a ligature audit workshop to ensure they fully understood the identification and management of ligature risks.
- Safeguarding training was mandatory for staff. Figures provided by the provider for Pelham Woods showed all staff had completed the training.
- Staff could describe different forms of abuse and had a good understanding of what warranted a safeguarding referral and the process of making a referral. The service kept a record of all safeguarding referrals made and we saw recent examples of how they had followed these up with the local authority. Staff were aware of the local authority safeguarding lead and how to contact them if they needed advice.
- The service had robust systems in place to ensure medicine was stored and monitored appropriately. This included regular monitoring of drugs liable for misuse. A pharmacist from a private company was contracted to visit the wards twice a week to carry out audits, check the emergency drug supplies and safely dispose of medicine if required. Weekly medication audits were visible to the clinical team using an online system called “liveview” which the clinical team reviewed and responded to within set timeframes.
- Qualified staff undertook a medicine competency test during their induction and agency nurses were required to complete a competency test when they started to ensure they met the Priory standards for medication administration.
- The service had a policy that did not allow visitors under 18 to enter the ward. However, the service had a training room which was used as a visitors’ room where children could visit relatives. Staff told us they preferred visitors to inform them when they intended to visit but were able to accommodate last minute visits as long it was not thought to have an adverse effect on the patient or visitors.

Track record on safety

- The service had not reported any serious incidents within the last 12 months. However, in the event of incidents being deemed as serious, staff were aware they needed to be escalated to senior management.

Reporting incidents and learning from when things go wrong

- The service reported incidents appropriately. Staff were aware of the process and which senior staff needed to

Good

Are services safe?

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be informed depending on the nature of the incident. We viewed the incident log for the last three months and saw that sufficient information was recorded along with initial actions taken.

- The service had a duty of candour policy and followed this appropriately. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person.
- The clinical team considered the requirements of the duty of candour through regular incident reviews and responded where identified. The duty of candour was also a standing agenda item on monthly clinical governance meetings.
- Learning from incidents took place during senior managers' meetings, shift handover, supervision, and reflective practice meetings and by email.
- Staff felt supported after incidents and were given opportunities to debrief.
- The psychology team supported staff to complete behavioural charts so they could analyse patients' behaviour. Staff told us this had helped the team act more consistently towards incidents that needed de-escalating.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at five patients' care records across both wards. All contained assessments of the patients' social and medical history upon admission to the ward.
- The current locum psychiatrist carried out a comprehensive physical health assessment on all patients. Physical health assessments included all patients' health issues and individualised physical health checks were carried out dependent on need. For example, patients on certain medicines, or high doses of medicine, had more regular checks in areas such as metabolism, renal functioning and risk of constipation.
- Physical health assessments were monitored centrally for quality and completion by the quality team via the data quality scorecard. This was a centrally monitored system Priory used to maintain quality across all services. In addition to this the hospital director also locally monitored the quality of health assessments via the service's documentation quality walk-around audit.
- The wards used the national early warning system (NEWS) which is a scoring system for physical health assessment which all staff were trained in using. There was a flow chart in the clinic room showing the process to follow. A physical health nurse also attended the unit weekly.
- Patients told us they had appointments with the dentist and optician, and had regular blood pressure and weight checks.
- Patients' care records contained a 'this is me' style document that listed likes and dislikes, my preferred routine, serious physical health needs, communication needs and any other relevant information. These were completed by the patient and supported staff to individualise care needs and recovery goals.
- All patients' care plans were up to date, personalised, holistic and recovery focused. They contained patients' views and their strengths and weaknesses. Patients had a copy of their care plans or it was stated if they had refused. The multidisciplinary team discussed care plans with patients weekly and updated them accordingly. The also carried out quarterly comprehensive care plan reviews.
- All information needed was stored securely and available to staff via the care notes computerised system.

Best practice in treatment and care

- The service currently followed the High Dependency Rehabilitation service model and aimed to move patients on to community rehabilitation units or supported accommodation.
- Medical staff followed national guidance when prescribing medication. One patient, who was on a higher than recommended dose of anti-psychotic medicine, had the advised blood tests to ensure their blood levels were with within range considered to be safe and effective.
- On Rosa Parks ward there was a staged approach to moving patients towards self-medicating to promote their independence. Self-medicating patients had been initially assessed by the psychiatrist to ensure they were suitable and safe to self-medicate, and had clear care plans which identified how they would move to the next stage. There was a policy that guided this practice.
- The service employed a part time (30 hours per week) clinical psychologist with an honorary assistant psychologist due to start in November. All patients received a psychological assessment upon admission and subsequently throughout their treatment. This included completing recognised scales to monitor patients' mood and anxiety levels. The psychologist provided access to clinical psychology and psychotherapy including dialectical behaviour therapy, coping skills group, trauma work and relapse prevention. The psychology team kept attendance records and gave patients the opportunity to give feedback. The team had some capacity to provide a few one-to-one psychology sessions a month. All psychological input was captured in patients' care notes.
- Psychologists worked with new patients on admission to complete psychological assessments of need.
- The service employed a full time occupational therapist (OT). The occupational therapist normally saw patients within 72 hours of admission. The OT carried out a number of recognised assessments with patients, such as 'the model of human occupational screening tool'. This tool determines the extent to which individual and environmental factors facilitate or restrict an individual's participation in daily life. Patients also had assessments to ascertain their community living and kitchen skills. The OT provided groups such as walking, current affairs, gardening, goal setting and fitness with the support of

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

technical instructors. They also provided recreational activities such as smoothie making and pampering sessions. Ward staff worked alongside the OT to facilitate these groups but this was reported to be a challenge as the ward staff were often fully engaged in observations and day to day management of the patient group. This had been identified as an area which required additional support. The OT kept a record of patients who attended groups and fed this back to the multi-disciplinary team at daily meetings.

- Each morning, patients attended a planning meeting where they decided which groups/activities they would attend. This information was displayed on the ward to remind patients and staff who was attending.
- Patients were registered with a local GP if their own was out of area. The service recorded when patients were next due to attend specialists such as dentists or opticians. A nurse ran a regular physical health clinic which provided health promotion advice to patients. They were also trained in smoking cessation and could provide this support to patients.
- The tools used to measure patients' recovery outcomes included health of the nation outcome scales (HoNOS). HoNOS is a routine clinical outcome measure recommended by the English national service framework for mental health that covers twelve health and social domains and enables clinicians to build up a picture over time of patients' responses to interventions. In addition to this the service was using CANSAS (Camberwell assessment of needs) in the patient's ward round and then every three months thereafter.
- The service had also been implementing the Safewards model which gives methods for reducing risk and coercion in inpatient wards. The feedback from the staff and the patients as that this had been an excellent way of bringing the staff and patients together to try to look at the way the wards were working.

Skilled staff to deliver care

- A full range of mental health disciplines and workers provided input to the ward. The multidisciplinary team included the ward manager, responsible clinician, lead nurse, occupational therapist and psychologist. There were regular meetings to plan and review patient care.
- Team meetings included a daily team handover meeting attended by the senior team on site and staff nurses. There was a weekly individual review by the doctor plus a monthly multidisciplinary team meeting with the patient for an individual care review (ward round). Monthly meetings included all members of the team and others the patient wished to invite.
- Staff we spoke to were appropriately qualified for the roles they were carrying out.
- Staff received a corporate induction and a local induction to ensure they were suitably prepared for their role. New staff were allocated a mentor and spent time shadowing experienced staff before they were counted in staff numbers. They were required to complete an induction pack which monitored when they had reached required competencies. Qualified nurses completed a medicine competency test before they administered medicine. There was an expectation also that all agency nurses completed this medication competency test before they could administer medication.
- All agency training information was held on site so the reception team could check agency staff were suitable trained before they could work. Reception staff contacted the agency on a regular basis to ensure this information was kept up to date. The agency that was used guaranteed a similar level of induction to that undertaken by permanent staff joining The Priory Group.
- Staff received regular supervision. The service had a system that ensured all staff were allocated an appropriate supervisor dependent on their discipline and level of qualification.
- Information provided by the service showed that between 1 August 2017 and 31 July 2018 91% of the staff had received regular supervision. In addition, regular weekly reflective practice sessions took place.
- The data showed that during the same time all staff had received an appraisal.
- The hospital director was experienced at addressing poor staff performance. They had previously worked in services which had been underperforming and successfully made improvements. There were no current issues with staff performance at the service.

Multi-disciplinary and inter-agency team work

- The service had a robust system to ensure information was shared across the team. Ward staff had two daily handovers and this information was handed over to the

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

MDT by the ward nurse in charge every morning. We observed them during meetings and handovers and found their discussions to be patient-centred and recovery focussed.

- The service had links with the local GP service. We saw many examples where the MDT had liaised with GP services to ensure patients were getting support for physical health issues.
- There were good working links with the local mental health services that would provide aftercare and care coordinators were regularly contacted regarding patient progress and attended care plan meetings.
- The service had a named contact with the local authority safeguarding team and all staff knew how to contact them.
- The service also had links to the local gyms, swimming pools and the local community college.

Adherence to the MHA and the MHA Code of Practice

- The service provided training in the Mental Health Act (MHA) and 95% of staff had completed this. Staff members had a good working knowledge of the MHA.
- Mental Health Act documentation to certify whether a detained patient had consented to treatment or to certify that a patient did not consent, or lacked capacity to consent, to treatment were available and completed correctly. They were kept in patients' care records and attached to their medicine charts. It was evident that regular audits to ensure MHA documentation and compliance were undertaken.
- Staff reminded patients of their rights in line with the provider's policy and the MHA Code of Practice. This was clearly documented within corresponding care plans.
- The service had access to an independent mental health advocate (IMHA), and their contact details were displayed on both wards. All detained patients were automatically referred to them. The IMHA visited the ward weekly and was currently supporting a number of patients.

Good practice in applying the MCA

- Most staff (95%) had received training in the Mental Capacity Act (MCA)**.** Senior members of the multidisciplinary team (MDT) had a good understanding of MCA principles and processes in ensuring patients' capacity had been assessed.
- The service had a MCA and Deprivation of Liberty Safeguards (DoLS) policy for staff to refer to. The service currently had no patients who were subject to a DoLS authorisation or awaiting a DoLS assessment.
- Patients' care records demonstrated evidence of informed consent, for example consent to treatment and consent to enable family members to be notified of issues in relation to the patients care.
- The MDT arranged best interest meetings when required to support patients to make decisions. We saw how a patient, who was prescribed a medicine that was potentially harmful, was supported in deciding whether they wanted to continue taking it. The MDT involved nearest relatives, advocates and physical health specialists to ensure the decision was in the patient's best interest.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed staff engaging with patients in a respectful manner and we found the wards to be calm positive and friendly environments. Staff made themselves available and there was emphasis on ensuring detained patients were receiving escorted section 17 leave.
- We observed many examples of positive interactions between staff and patients whilst observing groups and activities. We observed two patient reviews where the multidisciplinary team (MDT) fully involved the patients and gave them the opportunity to ask questions. The MDT could change their approach to suit different patients' needs and presentation.
- Most patients we spoke with felt that staff treated them with dignity and respect. They felt that recently staff had been more effective at motivating and reminding them to attend groups and activities. They told us that staff always knocked before entering their bedrooms. Patients' bedroom doors had observation panels and the default position for all panels was closed which meant that patients privacy was maintained in their bedrooms.
- Staff throughout the service appeared to understand the needs of individual patients.

The involvement of people in the care they receive

- The service had a clear admission process that included patients being fully orientated to ward and being provided with a welcome pack. The pack included information about members of the multidisciplinary team and included details of the role of the ward representatives. Information about psychology and occupational therapy services were included as well as detailed information about ward routines and expectations. Views of patients about their experience at Pelham Woods were also included in the document.
- The service also invited patients to attend the monthly clinical governance meeting.
- Patients and staff co-produced care plans and risk assessments ensuring that patients' views were clearly captured. The multidisciplinary team actively involved patients in all aspects of their care and treatment during weekly reviews. This was supported using an overhead projector that allowed patients to see any changes or updates that were implemented.
- Advocacy services were available to support patients. Advocates had been involved in best interests meeting and had attended a patient's review on their behalf. Advocacy details were clearly displayed within both wards.
- The service held a weekly patient forum meeting which gave all the patients the opportunity to have direct into the running of the hospital, the meeting was attended by the patients plus the consultant and the hospital director. This meant there was a direct link form the ward to the senior management of the service. The agenda covered items such as what did people find difficult over the last month and what had been positive, it also included discussions around patient activities on the ward. There were clear actions allocated which were picked up and fed back at the following meeting.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The ward normally admitted patients from the South of England who may be located in different parts of the country and needed to come back into Surrey.
- Patients were encouraged to take extended leave as part of their discharge plan. The service had a policy to ensure they would always return to their same bedroom unless it was part of their planned pathway to step down to the Rosa Parks semi-independent flats. Following their stay at the unit, patients were considered for other placements in consultation with their locality teams and clinical commissioning groups.
- The service had a robust approach to discharge planning. All patients had clear discharge plans and progress towards discharge was discussed during handovers, multi-disciplinary meetings and patients' reviews.
- The average length of stay for current patients was approximately 460 days. The service reported that there were currently no delayed discharges across the two wards. The service had regular contact with care coordinators to ensure they were supporting discharge plans, this meant that care-coordinators were kept up to date with patient progress and invited to care plan meetings.

The facilities promote recovery, comfort, dignity and confidentiality

- The main ward had rooms where patients could be provided with therapeutic activities. They also contained a main kitchen where patients could prepare meals, a kitchenette area to prepare hot and cold drinks, a dining area and a day area with a television. The ward was well maintained and the communal areas were bright and inviting.
- The communal garden areas of the ward were well maintained and the doors to the garden were open permanently; which meant that patients could access fresh air and an opportunity to get off the ward in to the garden whenever they wanted without restriction. CCTV cameras viewed the higher risk areas of the garden to ensure that staff could locate patients easily when required.
- The ward had computers available in the communal areas for all patients to use following a suitable risk assessment. Patients had their own log-on to the system which meant that if required the ward staff could review and support patients if necessary to ensure they were accessing the internet in a safe way.
- All patients had their own bedroom with ensuite facilities. There was a communal bathroom on each ward that contained a bath. Patients could personalise their bedrooms and risk assessed items such as televisions and radios providing they had appropriate appliance checks and risk assessments in place. Patients had keys to their bedrooms so they could take ownership on protecting their belongings. All bedrooms had a small lockable space where patients could keep valuables or their medicine if they were self-medicating.
- Psychologists, occupational therapists and technical instructors provided an individual timetable of activities that they evaluated with the patient on a quarterly basis. Activities included groups such as thrive and survive, mindfulness, Dialectical Behavioural Therapy, skills group, body and mind, fitness sessions and recovery workshops. Also, the service offered activities designed to develop the skills necessary to live independently such as budgeting and cooking.
- All patients we met with spoke highly of the meals provided by the service and felt that their individual dietary needs were met as well as the kitchen being able to make, from scratch, particular foods which they liked.

Meeting the needs of all people who use the service

- The service was accessible by patients or visitors with limited mobility and doors were wide enough to allow for wheelchair access.
- All current patients had English as a first language. We were told that patients with language needs could be supported by the service and were told that this had occurred at previously. Staff told us they would liaise with the advocacy service if they needed to access interpreter services and that the kitchen was able to make culturally appropriate food if required to meet the needs of the patient group.
- We saw up to date information including the Mental Health Act and independent mental health advocacy. We saw information that gave an overview of treatments, healthy lifestyles, advocacy services, CQC, how to complain, red, amber, green (RAG) system (with a clear explanation of both red and green behaviours) and weekly activities.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Listening to and learning from concerns and complaints

- Between 16 August 2017 and 19 July 2018, the service had received 15 complaints, seven of which had been upheld. These related to patients disturbing neighbours whilst in the garden area, patients not admitted being unhappy with the decision, and a patient being unhappy with how they were spoken to by agency staff. The service addressed these complaints with actions such as apologies and extra staff training.
- Within the same period the service received 14 compliments.
- Patients were aware that the complaints process was included in their welcome packs and displayed on the ward.
- Staff knew how to handle complaints appropriately. The community meeting was used to discuss informal complaints. However, they were aware that patients should be advised to write to the hospital manager if the complaint could not be managed informally. The hospital manager would then send the patient an acknowledgement letter and have the complaint investigated by someone independent from the ward.
- The hospital manager told us that complaints would be discussed at team meetings and used to identify learning.
- The organisation had a staff complaints booklet that answered questions staff may have had about how to manage complaints.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and values

- The service had a specific statement of vision and values aligned with the Priory Group vision and values. Local site values were created through coproduction to ensure all staff were invested in them. Staff told us their aim was to support patients to achieve their maximum potential.
- Staff enthusiastically told us about recent improvements made in areas such as care plans, physical health monitoring and patients' nutritional needs. They were proud of their work and the progress patients were making.
- All staff spoke highly of the hospital manager and newly appointed ward manager and found them approachable and progressive. They were based on the wards supporting the day to day clinical practice of the staff team.
- The service had bi-monthly employee awards focusing on the Priory values and how the individual staff members were achieving these values.
- At each Senior Management Team meeting the agenda identified each departments achievement during the previous month.
- Staff were aware who other senior managers were who worked across the provider's sites. They told us they regularly visited the service and were generally approachable.
- It was clear from speaking to the staff and patients that the local leadership of the service had an inspiring shared purpose and were striving to deliver and motivate staff to succeed. In the year the new hospital director had taken over, comprehensive and successful leadership and clinical strategies had been put in place to ensure clinical delivery and to develop and improve the culture of inclusion within the service across all equality groups. Examples of this include the implementation of the "Safewards" structure with lots of patient participation and the quarterly "morale-o-meter" where the results are discussed in the monthly staff "your say" forum to generate answers on how to improve and how the senior management team can best support the staff.
- Both the hospital manager, the ward manager and staff said they had an 'open door' policy. Examples were given of staff speaking with managers about their concerns for patients, such as the need to increase nursing observation. This was done immediately and staff told us they felt their opinions were respected.

Good governance

- There was a systematic governance based approach to continually improve the quality of its services and an environment in which staff could provide high quality care. Several methods were used to achieve this, such as a monthly quality review, a comprehensive clinical audit programme, and monitoring of specific indictors relating to patient safety. This included review of incidents, accidents, complaints, compliments, allegations of abuse, absconding and use of restrictive physical interventions.
- Managers used monitoring tools to ensure staff kept up to date with their mandatory training, supervision and annual appraisal. We reviewed this information and the Hospital Director told us of any associated plans in place for staff who were overdue.
- Training, supervision and appraisal rates were above the provider requirement of 92% with the service running at 96% in all statutory and mandatory training at the time of the inspection. This figure was reported on a weekly basis to the chief executive of the company and monitored through the onsite clinical governance arrangements. The service had recently received a letter of commendation from the chief executive for consistently high performance in relation to mandatory training.
- The service used a local risk register which was updated each month as part of the senior management team meeting. The clinical governance meeting identified and reviews all risks that should be included in the risk register.
- We saw there were sufficient staff to ensure patients received the right care for them at the right time. The service considered patients fluctuating needs and ensured floating staff could dedicate their time where it was most required.
- The service demonstrated commitment to best practice performance and risk management systems and processes. The service reviewed how they functioned

Are services well-led?

Outstanding ☆

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and ensured that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. We saw various examples of the provider using the results from the information it had collected to maintain and improve the quality of the service and various action plans had been completed or were being monitored to ensure they were achieved.

Leadership, morale and staff engagement

- The staff survey had been completed at the end of April 2018. The results from this were displayed as 'You said, we did' in the staff area.
- Staff were proud of the work they did and of the service. The monthly senior management team meeting was split into two parts, the first part explored communication across the service and provided the opportunity to review achievements for the previous month and encouraged positive comments and praise between the staff. The second part focussed on business development and explored the quality dashboard, patient's safety issues and challenges and priorities for the month ahead.
- There were consistently high levels of constructive engagement with staff and patients, including all equality groups. Rigorous and constructive challenge from patients, the public and stakeholders is welcomed and seen as a vital way of holding the service to account.
- The service had been developed with the full participation of those who use them, staff and external partners as equal partners.
- There were currently no bullying and harassment cases within the service and the Hospital Director was experienced in dealing with these cases as they had managed them in previous services.
- Staff we spoke with told us they knew how to use the whistleblowing process and felt confident to raise concerns without fear of victimisation.
- Staff had opportunities to discuss career progression in their supervision and appraisal. Staff told us the service had been receptive to their individual needs and skills. Leadership development opportunities were available for staff who wanted to become leaders, and staff who wanted to increase their clinical skills could attend training and education courses.
- Staff were open and honest with patients and carers when something went wrong. We saw this reflected in the complaints and incidents we reviewed. Carers also confirmed this and said the service always kept them updated.

Commitment to quality improvement and innovation

- Pelham Woods had been accredited by the accreditation for inpatient services (AIMS) for the period 11 April 2017 to 10 November 2018. AIMS are a set of standards that identify and acknowledge high standards of organisation and patient care.
- Staff completed a ligature audit workbook when they started a Pelham Woods to ensure that all staff fully understood the management of ligature points.
- Pelham Woods was committed to patient inclusion and had patients on all service development forums and had included patients in the development of the core values of the service.