Affinity Healthcare Limited

Cheadle Royal Hospital

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

- On this inspection we inspected the acute wards for adults of working age and psychiatric intensive care units. We rated these as: requires improvement overall; inadequate for safe, requires improvement for well-led; and good for effective, caring and responsive.
- We have used ratings from previous inspections of other core services to aggregate ratings to location level in line with our guidance.
- This inspection did not change the overall location rating which remains as requires improvement. However, the location rating for safe went down to inadequate. The location rating for well-led remains as requires improvement. The location rating for effective, caring and responsive remains as good.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this core service went down. We rated it as requires improvement because: • The service did not fully use effective systems and processes to safely prescribe, administer, and record medicines. Physical health screening and monitoring was not always carried out in accordance with national guidance. • Staff were not always completing and recording physical health monitoring after the use of rapid tranquilisation, in accordance with national guidance. Records were not always completed correctly, or consistently. • The service was not always well led and although there were governance processes, these did not always identify, resolve and monitor gaps in the provision of care. There were breaches of regulations at the last inspection in April 2022 under well-led. There had been progress in some of these areas, but they had not all been addressed. • Staff had not always completed the necessary training and received an appraisal. However • The ward environments were mostly safe and clean. The wards usually had enough nurses and doctors. Staff assessed and managed risk. They minimised the use of restrictive practices, and followed good practice with respect to safeguarding. • Staff developed holistic, recovery-oriented care plans. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards, although there were vacancies across the service. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

Summary of findings

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Summary of findings

Contents

Summary of this inspection

Background to Cheadle Royal Hospital

Cheadle Royal Hospital provides mental health services to adults, and to children and young people. It has 13 wards that provide inpatient services across the following core services: acute wards for adults of working age and psychiatric intensive care units (PICU); child and adolescent mental health wards; and specialist eating disorder services.

This inspection was of the 7 acute and PICU wards:

- Alder – acute ward for up to 14 men and women
- Maple – acute ward for up to 15 men and women
- Featherstone – PICU for up to 10 men
- Pankhurst - PICU for up to 10 women
- Willows - PICU for up to 10 men
- Fern – ward for up to 10 women with an emotionally unstable personality disorder
- Mersey Lodge – bespoke service for one person.

Cheadle Royal Hospital registered with the Care Quality Commission in December 2010. It is provided by Affinity Healthcare Limited, operating as the Priory Group. It is registered to provide the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983; and Treatment of disease, disorder or injury.

This was an unannounced comprehensive inspection of the acute and PICU wards. It was carried out in response to information of concern about the service.

Acute wards for adults of working age and psychiatric intensive care units were last inspected in April 2022, as part of an inspection of the whole hospital. Acute wards for adults of working age and psychiatric intensive care units were rated as good overall; with a rating of good for the safe, effective, caring and responsive domains, and requires improvement for the well-led domain.

All patients on the acute and PICU wards were funded by the NHS.

The service had a manager registered with the Care Quality Commission.

At the last inspection the service received requirement notices for breaches of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach of regulations had still not been fully met. The detail of this is included in the report.

What people who use the service say

Patients and family members we spoke with were mostly positive about the service. Most patients told us they felt safe, and that most staff were kind and supportive.

Most patients and family members felt able to raise any concerns they had. Some patients felt that their individual needs were not attended to, and they had raised complaints about this. Patients were aware of the community meetings on the wards - where they could raise concerns - and of the advocacy service.

Summary of this inspection

Patients told us that staff could be busy, but generally did not raise any concerns about staffing levels. They told us there were less staff at night, and although there was the occasional staff member there had been problems with, they were mostly positive.

Patients felt involved in their care and had access to activities, though there was less to do at weekends. They were provided with information about their care and medicines, and participated in their weekly ward round.

Most patients said the environment was clean and maintained. However, some highlighted that parts of the building were old and worn. Some patients reported that other patients could be messy, but that this was usually quickly cleaned up.

Patients who were detained under the Mental Health Act were made aware of their rights.

How we carried out this inspection

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit the inspection team:

- visited all 7 wards, looked at the ward environments and observed how staff were caring for patients
- spoke with 22 patients or their relatives
- spoke with the registered manager
- spoke with 50 other staff
- reviewed 22 care records of patients and other care related documents including prescription charts and observation records
- spoke with staff from the advocacy services
- attended 3 meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service MUST ensure that patients have appropriate physical health screening and care plans, and that any necessary ongoing monitoring is carried out and recorded, in accordance with national guidance. This should include venous thromboembolism (VTE) screening on admission. (Regulation 12(1)(2)(a)(b)). This was included in a warning notice to the provider telling them to improve by 31 July 2023.

Summary of this inspection

- The service MUST ensure that physical health monitoring is carried out and recorded after the use of rapid tranquilisation, in accordance with national guidance. (Regulation 12(1)(2)(a)(b)). This was included in a warning notice to the provider telling them to improve by 31 July 2023.
- The service MUST ensure that medicines are safely stored, managed and administered, and that there is a robust process for medicines reconciliation. (Regulation 12(2)(g)). This was included in a warning notice to the provider telling them to improve by 31 July 2023.
- The service MUST ensure that there are robust systems and processes that assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others. (Regulation 17(2)(b))
- The service MUST ensure that all staff have completed their mandatory training. (Regulation 18(2)(a))

Action the service SHOULD take to improve:

- The service should ensure that staffing levels are kept under review, so that there are appropriate qualified staff on duty at all times, including at night (Regulation 18).
- The service should ensure that seclusion records are completed consistently, so that it is easy to monitor and check (during and after the event) that the necessary safeguards have been implemented (Regulation 17).
- The service should ensure that the policy for the opening of patients' post is kept under review, to balance keeping patients safe with least restrictive practices (Regulation 13).
- The service should ensure that the ongoing maintenance and decoration of the hospital is kept under review, so that patients are cared for in a suitable environment (Regulation 15).
- The service should ensure that all staff receive an annual appraisal (Regulation 18).
- The service should consider reviewing the process for obtaining and recording information from outside the hospital, to ensure that staff have ready access to information and that it is not delayed or lost.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Inadequate	Good	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

Safe	Inadequate
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

All wards were safe, clean, equipped, furnished and maintained.

Safety of the ward layout

The main hospital was built in the 19th century, and had been updated and extended to other buildings within the grounds since that time. Each of the wards had a different layout and design, depending on their age and where they were situated.

Staff could not easily observe patients in all parts of the wards. Some of the wards had low ceilings (the two wards in the basement/lower ground floor); and several wards had narrow corridors and layouts that created low visibility areas and blind spots. Alder ward was in a standalone building in the grounds of the hospital, with winding corridors some of which were narrow with limited visibility. Staff took action to mitigate these risks, which included risk assessments of individual patients, regular observation and CCTV covering communal areas. Fern ward was also a standalone building, but it was a modern building that was light and airy, with good visibility.

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Environmental risk assessments which included ligature audits had been carried out on all ward areas. An action plan was developed following the assessments, but it did not always have completion dates or confirm the actions had been completed. Actions had been taken to mitigate risks which included anti-ligature furniture and fittings in patients' bedrooms, and in high risk areas where patients were unsupervised.

The ward complied with guidance on the use of mixed sex accommodation. Alder and Maple wards admitted both men and women, but the other wards were single sex. Alder and Maple wards had separate corridors for male and female bedrooms, which had their own bathrooms and toilets. The wards had some 'swing' beds that could be used for either men or women, but would not be used for both at the same time. There had been no occasions when men or women had a bedroom on the corridor of the other gender. Mixed wards had a female-only lounge.

Staff had access to alarms and patients had access to a nurse call system. Staff knew how to call for help in an emergency, and carried alarms with them. There were nurse call alarms in patients' bedrooms and bathrooms. There was a programme of regular testing which included the nurse call system.

Each ward had a map of where the higher and lower risk areas were, and storage of emergency equipment such as ligature cutters and medical emergency equipment.

Maintenance, cleanliness and infection control

Most ward areas were generally clean, maintained, and furnished. There was an ongoing programme of maintenance and refurbishment across the hospital. Some areas of the hospital were in need of cleaning and repair, though most of these were in areas that were not directly accessible to patients. However, the entrance to Maple ward was through the former ballroom, which had peeling wallpaper and damp/cracks on some of the walls. There was a smell of drains in the visitors' room on Maple ward, which had been persistent for some time. A bedroom corridor on Pankhurst ward had a musty smell, which appeared to come from the laundry room which had limited ventilation. Managers told us that maintenance was ongoing, but was challenging in some areas of the building due to its age. Blocked drains were not uncommon, and were typically caused by wet wipes or polystyrene cups. There was a process for dealing with this, but it could take time due to the extensive work required to gain access to the pipework in some parts of the building.

The wards were generally clean. However, the main building was a listed building and had decorative stone window frames which could not be changed. The inside of these windows had fixed secondary glazing to improve safety and insulation. The secondary glazing was not easy to remove, and dirt had built up in the space between it and the main window. A quarterly cleaning audit was carried out of each ward. The results of these were mostly positive.

Staff followed infection control policy on most occasions, including handwashing. Staff had access to personal protective equipment (PPE), such as aprons and gloves. Staff had worn PPE when required during the COVID-19 pandemic. There were no longer any national restrictions regarding COVID-19, but staff followed local policies when staff or patients had the virus. However, on one ward we found urine samples stored in the same fridge as medicines, which is an infection control risk.

Seclusion room

Seclusion rooms were consistent with the Mental Health Act Code of Practice. They allowed clear observation and two-way communication, and had a toilet and a clock. Each of the 3 PICU wards had a seclusion room. If seclusion facilities were needed for a patient on the acute wards, they would use seclusion facilities on the PICU wards, or other seclusion rooms in the hospital.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The size and layout of the clinic rooms varied between wards. Many of the rooms were small and crowded, but contained the necessary equipment. Patients were not examined in the rooms. Emergency equipment was available on all of the wards and was routinely checked. On some of the wards the emergency bag was located on the top of cupboards, which may be difficult for some staff to reach.

Staff checked, maintained and cleaned equipment.

Safe staffing

The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

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

Requires Improvement

Nursing staff

The service usually had enough nursing and support staff to keep patients safe. Staff and patients told us that there was a lot of pressure on staffing levels, and it was often very busy, but there were usually enough staff to keep patients safe. There were occasions when there was not a qualified nurse on a ward, or a preceptor (newly qualified) nurse was the only nurse so was in charge of the ward. However, on these occasions nursing cover had been provided by senior nurses from elsewhere on the site.

The service had vacancies for nursing staff and health care assistants. Out of 43 nursing posts, 13 were currently vacant with 9 people going through the recruitment process. Out of 170 healthcare assistant posts, 39 were currently vacant with 23 people going through the recruitment process. Staff vacancies were included on the service's risk register, and were regularly reviewed by managers. There was an ongoing programme of recruitment.

The service used bank and agency staff to cover when needed for vacancies, staff sickness and increased observation levels. Managers mostly limited their use of bank and agency staff, and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Agency workers were required to complete an induction pack.

Managers supported staff who needed time off for ill health. The average sickness rate across the hospital in the last 12 months ranged from 3 to 6%, and was currently at 4.9%. This was comparable with the most recent information from the NHS which showed an average sickness rate of 5.4% up to November 2022.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely. The hospital had 13 wards, and staff could be moved across the site to cover other wards if required.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to a ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Each ward had a full time consultant psychiatrist and a speciality grade doctor. Mersey Lodge had one patient and was covered by the medical director, who was also one of the ward consultants. There were no consultant vacancies, and a speciality grade doctor vacancy on 2 of the wards. Vacancies and sickness were covered by locum doctors.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. Out of hours medical cover had been provided by the speciality grade doctors. However, a new system had been introduced the week before the inspection. An external company was contracted to provide out of hours medical cover, with a rota of three doctors who would be based onsite and cover the whole hospital. Managers told us that they were not psychiatrists, but had received an induction which included reviewing a patient in seclusion, and were trained in advanced life support in the event of a medical emergency. The consultants and speciality grade doctors remained on a rota for additional advice and support to the out of hours doctors. This complied with the Mental Health Act Code of Practice which permitted duty doctors who are not approved clinicians to carry out medical reviews provided they were competent and had access to an on-call approved clinicians.

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

Requires Improvement

Mandatory training

Staff had not always completed and kept up to date with their mandatory training. At the time of inspection this was an average of 83% of staff across the wards inspected. This ranged from 77% of staff on Maple Ward to 90% of staff on Alder Ward. However, there were 3 wards with lower levels of compliance. Maple ward had lower levels of training in Deprivation of Liberty Safeguards (62%), diversity & inclusion (70%), fire safety (67%), Mental Capacity Act (46%), reducing restrictive interventions (69%) and the Mental Health Act (69%). Pankhurst ward had lower levels of training in cyber security (68%) and the Mental Capacity Act (74%). Alder ward had lower levels of training in reducing restrictive interventions (60%).

The mandatory training programme was comprehensive and met the needs of patients and staff. It included basic or immediate life support, reducing restrictive interventions and safeguarding adults, children and young people. Oliver McGowan training on learning disability and autism was introduced in February 2023 and staff were in the process of completing this.

Managers monitored mandatory training and alerted staff when they needed an update. Staff had access to the provider's e-learning system. Most training was online, but where necessary training was carried out face to face. Face to face training included basic and immediate life support, and reducing restrictive interventions.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments relating to their mental health for each patient on admission and reviewed this regularly, including after any incident. Each patients progress and care, which included risks, was reviewed during their weekly multidisciplinary team meeting.

At the last inspection we identified that patients did not routinely have a venous thromboembolism (VTE) risk assessment completed on admission as recommended by NICE guidance and in accordance with the provider's own policies. Patients were still not receiving a VTE risk assessment on admission. However, there had been no recorded hospital acquired VTEs at the hospital.

Management of patient risk

Staff knew about any potential risks to each patient and acted to prevent or reduce them. Staff identified and responded to any changes in risks to, or posed by, patients. Staff attended a handover meeting at the beginning of each shift, where information about individual patients was communicated. This included information about specific patients, and about more general risks such as the environment or maintenance. Staff had access to written information about risk. Some patients were on enhanced observations and had at least one member of staff with them at all times. Staff carrying out these observations had a summary of information about the patient and the reason they required this level of support.

Due to the layout of the wards, staff could not easily observe patients in all areas on all the wards. Staff followed procedures to minimise the risks of patients harming themselves or others, including when they could not be easily observed.

Staff followed the service's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Each ward had a member of staff designated as a security nurse on each shift. Their role included checking environmental risks, dealing with patient's property, and monitoring patients and visitors entering and leaving the ward which included restricting potentially harmful objects. Following an incident where harmful items were delivered in the post, the service had introduced a policy for monitoring patients' post. Staff told us this would be individually risk assessed, but all patients would be expected to open any packages in front of staff, or if the patient agreed for staff to open them in front of the patient to ensure there were no high risk items. If a patient refused then staff would consider the action to take in their best interests of the patient based on their level of risk. This is a provider-wide policy, that states it should be reviewed through governance at each hospital, and individually risk assessed for each patient.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. In the last 12 months there had been 578 incidents of restraint. Out of these there had been two incidents that involved prone (face down) restraint which had been for a short period. Mersey Lodge had 4 episodes of restraint, with Alder, Maple, Featherstone and Willows ranging from 37 to 57. Pankhurst and Fern wards had the highest number of restraints with 188 and 213 over the last 12 months. This had reduced since our previous inspection.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff were aware of the necessary checks required when a patient was given rapid tranquilisation. However, this was not consistently recorded in care records, so it was not possible to confirm that this had been carried out.

When a patient was placed in seclusion, staff did not always keep clear records in the provider's seclusion forms to easily see that the safeguards were met. During 2022 there had been 149 episodes of seclusion. This ranged from 4, 8 and 9 episodes on Alder, Maple and Fern wards to 42 episodes on both Willows and Featherstone wards, and 44 on Pankhurst ward. The use of seclusion each month varied between wards and ranged from none to 12 on Pankhurst ward. Staff completed a paper seclusion pack for each episode of seclusion. We reviewed 13 seclusion packs There were gaps in the paper seclusion records, but the necessary information was recorded in the electronic record, but this was not easy to find or to monitor that seclusion monitoring had been carried out correctly.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. In 2022 there were 10 recorded episodes of long term segregation on the PICU wards and none on the other wards. Mersey Lodge was not recorded as long term segregation although this had been documented elsewhere. However, Mersey Lodge provided a bespoke service for one patient and had extensive input of other healthcare organisations and commissioners.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff were up to date with their safeguarding training, which included this training in relation to both children and adults.

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

Requires Improvement

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The social work team led on safeguarding in the hospital. Referrals were sent to them for an initial investigation, and were then discussed and investigated further if necessary. If a referral to the local authority was required this would usually be made by the social work team.

Managers and staff had been involved in investigations into serious incidents. When safeguarding concerns were identified, immediate action was taken to keep people safe, ahead of a further investigation. Managers and the social team discussed the management of safeguarding and any identified themes at the monthly quality assurance meeting.

Safeguarding information was maintained on a provider-wide tracker, and the information stored through a local email box. This was in the process of being transferred over to the online incident management system.

Staff access to essential information

Staff had access to clinical information, but it was not always possible to easily find information as it was not always consistently recorded and maintained. Clinical records were stored both electronically and on paper.

Patient notes were not always comprehensive. Staff documented assessments, care plans and progress notes in the electronic care record. Overall they contained the necessary information, but were variable across the wards in terms of their level of detail, person-centredness and recovery focus. There were some records, particularly with regards to physical healthcare, where care plans either did not exist, or did not contain enough detail to enable staff to monitor, provide care and treatment, or support the patient in managing their own condition. Physical health observations (such as blood pressure) were recorded using a recognised tool (National Early Warning Score 2) or NEWS2). However, they were not recorded consistently, and action was not always taken or documented as indicated by the tool.

Staff did not have access to a robust and consistent process for receiving and managing patient information that came from outside the hospital. For example, information (such as about a person's medicines) from GPs was sent either to an individual member of staff, or to a shared email address, and the information was then pasted into the electronic care record. There was no oversight of the shared email addresses, and staff had no access to information in the shared email address after 3 months.

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

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always review the effects of medicines on each patient's mental and physical health, and it was not always clear that appropriate action was taken in response to this.

Staff did not always store and manage all medicines and prescribing documents safely. We found a number of individual examples of medicines not being stored or recorded correctly. Medicines were not always available for patients. All staff had access to the clinic room where medicines were stored, though only certain staff (such as registered nurses) had access to the medicines' cupboards. Medicines' disposal bins were not tamperproof but were stored in locked clinic rooms. Clinic room and fridge temperatures were generally monitored and usually in an acceptable range.

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

Requires Improvement

Staff did not always follow systems and processes when prescribing, administering, and recording medicines. Staff did not always manage medicines in line with the provider's policy. Body maps were available for staff to record where a medicine patch had been applied to ensure that patches were used safely, but staff were not using them. We found examples of a patient refusing a medicine for several weeks, which may put their physical health at risk. This was recorded on the medicines chart, but not noted in the care records, and there was no record of any discussion or action taken. The controlled drugs and drugs liable to misuse registers were not always completed correctly. This included missed signatures and crossings out. These were also highlighted by the external medicines audit. The service had an Accountable Office for controlled drugs, and was part of the controlled drugs local intelligence network (CDLIN).

Staff reviewed each patient's medicines in the weekly multidisciplinary team meeting. However, staff did not always complete medicines records accurately and keep them up to date. An external pharmacist visited the site each week and, over a period of time, visited all 13 wards including those in this core service. They identified any issues or errors, such as gaps on prescription charts. These were all logged on a database which was accessible by both the external pharmacist and the service. Staff took action to resolve these issues which were then marked as completed when confirmed by the pharmacist on future visits. Themes and repeating issues were discussed in the medicines management meeting.

The service did not have a process for ensuring staff followed national practice to check patients had the correct medicines on admission to the hospital. The provider implemented a revised policy for this during our inspection, but this had yet to be embedded. Staff contacted each patient's GP when they were admitted to hospital to find out what medicines they were prescribed.

Staff learned from safety alerts and incidents to improve practice. The service shared information about relevant safety alerts with staff. This was available online, and was included in bulletins and emails sent to staff.

There is specific guidance regarding the prescribing of sodium valproate for women of childbearing age, due to potential risks to the foetus. At the last inspection there was no process for ensuring that women of childbearing age who were prescribed sodium valproate had a pregnancy prevention plan in place. At this inspection there was still not a robust process for ensuring this was implemented and monitored.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. However, staff did not always review the effects of each patient's medicines on their physical health in accordance with National Institute for Health and Care Excellence (NICE) guidance. When rapid tranquilisation was administered, staff did not always ensure physical observations were checked in accordance with their own policy.

Staff did not always review the effects of each patient's medicines on their physical health in accordance with NICE guidance. Staff used a recognised tool (NEWS2 or National Early Warning Score 2) for recording patients' observations, such as pulse and blood pressure. The NEWS2 included guidance on the action staff should take if the observations were outside a healthy range. In some cases staff had recorded a patient's observations which were outside the normal range, but there was no record as to whether the observations had been rechecked or escalated in accordance with the tool's guidance or hospital policy. However, the overall NEWS2 was reviewed as part of the multidisciplinary team meeting each week.

Emergency medicines were available, which included oxygen and antidotes to drug overdoses.

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

Requires Improvement

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

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

Managers usually debriefed and supported staff after any serious incident. Staff feedback was mixed, but most told us there was usually but not always a debrief with staff and patients following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where necessary. Staff told us they did not always receive feedback from the investigation of incidents. However, information was shared through meetings, emails and bulletins that included incidents and learning from this and other services.

Managers reviewed incidents through the patient safety meetings. This included incidents that had occurred at Cheadle Royal Hospital, and learning from incidents that had occurred in other hospitals. There was evidence that changes had been made as a result of feedback. This included changes to the environment to make it safer following incidents at other hospitals. The process of reviewing incidents had been improved, and serious incidents were now signed off by managers from a different part of the service.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. However, some care plans lacked detail on managing patients' long-term physical health conditions.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. This was carried out by staff from the multidisciplinary team that included nurses, doctors, psychologists and occupational therapists. Staff developed a care plan for each patient that met their mental health needs.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Patients were usually able to manage their own long-term health conditions. However, there were not always care plans for patient's physical healthcare needs that provided detailed information to enable staff to monitor, provide care and treatment, or support a patient in managing their own condition.

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

Requires Improvement

Care plans were mostly personalised, holistic and recovery orientated. Overall they contained the necessary information, but were variable across the wards in terms of their level of detail, person-centredness and recovery focus.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service. Staff mostly delivered care in line with best practice and national guidance. This included guidance from the National Institute for Health and Care Excellence (NICE) on the treatment of specific conditions including schizophrenia, depression and personality disorder, and with regards to managing violence and aggression and self-harm. The exceptions where staff were not following NICE guidance relating to venous thromboembolism assessments, monitoring the prescribing of sodium valproate for women of childbearing age, and monitoring of physical health after rapid tranquilisation are reported under the safe key question of this report.

Patients on the psychiatric intensive care units and Fern ward had access to a range of psychological assessments and interventions, based on their individual needs. Staff discussed new guidance and best practice at the monthly clinical governance meetings, and at professional forums such as the monthly academic meeting for doctors.

Staff identified patients' physical health needs, and ensured that patients had access to physical health care, including specialists as required. However, this was not always recorded in their care plans.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. However, food and fluid charts were not always fully completed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients had access to exercise facilities within the hospital, and there were healthier food choices on the menu. Patients could access smoking cessation support which included electronic cigarettes or vapes.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The multidisciplinary team used Health of the Nation Outcome Scales (HoNOS), which is a recognised tool to measure the health and social functioning of people with a mental illness. The psychology and occupational therapy teams used a range of research-based therapeutic scales depending on the needs of the patient.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of patients, but there were vacancies on some of the wards. All wards had access to psychology and occupational therapy staff, but the qualifications/skills and number of these varied depending on the needs of the patients, and the current vacancies. The service had an ongoing recruitment for allied health professionals.

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

Requires Improvement

The psychology and occupational therapy teams worked across the whole hospital, but each ward usually had its own specific staff. The psychology team had a mixture of clinical psychologists, assistants and trainees. They provided a range of interventions that included assessment, formulation (this is broadly about understanding patient's needs and how staff can work with them), group and 1-1 work with patients, and reflective practice with staff.

Vacancies in the occupational therapy team meant that not all patients had a qualified occupational therapist on their ward. All three psychiatric intensive care units had no occupational therapist, but had technical instructors and occupational therapy assistants that were supervised by an occupational therapist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Ward staff received a two week induction – the first week was for training, which included mandatory training such as reducing restrictive interventions and safeguarding. During the second week staff had supernumerary time on the ward. New agency staff completed an induction pack which included security and enhanced observations.

Managers supported staff through regular, constructive appraisals of their work. On average 80% of staff on the wards had completed their annual appraisal. There were lower levels of appraisal on Pankhurst ward (63%) and Fern ward (67%). Managers told us that staff appraisals were carried out from January to April each year, and this was still in progress at the time of inspection.

Medical staff, occupational therapists, psychologists and social workers accessed their own internal and external supervision arrangements where required, and maintained their professional registration requirements.

Managers supported staff through regular, constructive clinical supervision of their work. Ward managers maintained supervision trackers to monitor this. Staff on Fern ward, Mersey Lodge and the psychiatric intensive care units had access to group supervision or reflective practice.

Managers made sure staff attended regular team meetings or gave information to those that could not attend.

Managers made sure staff received any specialist training for their role. For example, staff on Fern ward had all received some level of training, suitable to their role, on dialectical behaviour therapy (DBT).

Managers recognised poor performance, could identify the reasons for this, and dealt with it.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Ward teams had effective working relationships with other teams in the organisation. The scheduling of ward rounds varied between wards, which could make it difficult to give patients and other organisations a fixed time to attend meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

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

Requires Improvement

Ward teams generally had effective working relationships with external teams and organisations. Access to beds on the acute wards, and some of the psychiatric intensive care units, were managed though an established relationship with a nearby NHS trust. Other beds were purchased on an individual basis, and commissioners could be from across the country. This could create difficulties in accessing local teams and resources, but staff worked hard to overcome this and ensured patients got the support they needed. Community mental health teams attended multidisciplinary team meetings, either in person or through videoconferencing.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice, and could describe the Code of Practice's guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The Mental Health Act administrators monitored the implementation of the Act and scrutinised paperwork to ensure that patients were lawfully detained, and that their rights were upheld.

Patients had easy access to information about independent mental health advocacy. Patients who were detained under the Mental Health Act received advocacy services from an independent mental health advocate (IMHA). Informal patients received a general advocacy service from another provider.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand. This was repeated as necessary and recorded clearly in the patient's notes each time.

Staff made sure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with their consultant psychiatrist. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for this under Section 117 of the Mental Health Act. Staff worked with patients and staff in their home area to ensure they were able to receive any support they required on discharge.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

There was a clear policy on the Mental Capacity Act and the Deprivation of Liberty Safeguards. Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff knew where to get advice on the Mental Capacity Act and the Deprivation of Liberty Safeguards.

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

Requires Improvement

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Best interest meetings were carried out involving staff from outside the hospital and family members when appropriate.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary. There had been no Deprivation of Liberty Safeguards applications made in the last 12 months.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Patients said staff treated them well and behaved kindly. Patients gave us positive feedback about staff and said that most staff were helpful and supportive.

Staff gave patients help, emotional support and advice when they needed it. Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward as part of their admission. Patients were shown around and provided with information about the ward. However, some patients were very unwell on admission so the information they were provided with was limited, or they could not remember what they had been told. Some patients said that staff were helpful, and information was available but you had to know what to ask for, which could be difficult in the early stages of admission.

Staff involved patients in their care planning and risk assessments. Most patients told us that they were involved in their care, and attended the multidisciplinary team meeting each week. They had any medicines they were taking explained to them.

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

Requires Improvement

Patients could give feedback on the service and their treatment and staff supported them to do this. Each ward held a regular community meeting where patients could raise concerns, and receive updates. Patients were asked to complete a feedback form when they were discharged. This was available in paper and electronic format. However, the uptake of this was low.

Patients could access advocacy services. Different organisations provided advocacy services depending on whether a patient was admitted voluntarily, detained under the Mental Health Act, or subject to restrictions under the Mental Capacity Act. Information about the advocacy services was on display. Advocates met with patients directly, and also supported them by attending their multidisciplinary team meetings. Advocates were usually able to attend multidisciplinary meetings when required, although it could sometimes be difficult as staff did not always provide the advocates with timely notice of the dates and times of when patients would be reviewed.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Patients told us that their relatives were involved in their care, provided that the patient wanted this. Families were able to attend multidisciplinary team meetings to discuss the care of their relative. Families were able to visit their relatives throughout the day.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not usually have to stay in hospital when they were well enough to leave.

Bed management

Patients admitted to the wards were all funded by the NHS. Patients admitted to the acute wards were referred by a central hub, on behalf of several NHS trusts in the North West. Patients were admitted from across the country to the psychiatric intensive care units and to Fern ward.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. However, patients could be moved to wards in their home area when a bed became available.

When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning.

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

Requires Improvement

Discharge and transfers of care

Most patients did not have to stay in hospital when they were well enough to leave. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. At the time of our inspection there were 15 patients who were ready to move to a different type of service or accommodation, but a suitable placement or ward had yet to be identified or be available. Staff at the hospital were working with staff within NHS hospitals and the relevant community mental health teams and others to keep any delays to a minimum.

Staff planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom. There were quiet areas for privacy. The food was of good quality and patients could access hot drinks and snacks at any time.

Each patient had their own bedroom. Patients had a secure place to store personal possessions. On some of the wards this was in patients' own bedrooms, and on others there were storage facilities elsewhere on the ward.

Staff used a full range of rooms and equipment to support treatment and care. The facilities available varied between wards. Fern ward had light and airy rooms for therapy and activities. On other wards activities took place in the communal areas. The wards had access to a gym. There was a small occupational therapy kitchen/room and gym on the lower floor. These were small rooms without natural lighting.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private. Most patients had, or had access to, a mobile phone.

The service had an outside space that patients could access easily. The hospital was set in large and attractive grounds. Each ward has its own outdoor space that was directly accessible from the ward.

Patients had access to hot drinks and snacks. This was risk assessed on each ward – on some wards patients had free access, and on others patients had to request hot drinks from staff. The service offered a variety of good quality food. Patient feedback was variable about the food available, but most patients gave positive feedback about the choice.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work where this was appropriate. Many patients were in hospital for a short period of time, during the acute phase of their illness, and did not live in the local area. Occupational therapists carried out home visits with patients when this was necessary, to support them before discharge.

Staff helped patients to stay in contact with families and carers. Visitors were encouraged to visit the hospital and attend multidisciplinary team meetings, with the agreement of the patient. Patients could access the local community when they went on leave.

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

Requires Improvement

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication or other specific needs. Not all areas of the hospital were easily accessible by patients, due to the age and design of the building. There were facilities for people with limited mobility or who used a wheelchair on some of the wards. Patients had access to communication devices where these were required.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information on display and on the provider's website.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. Patients may be admitted from anywhere in the country, though most were from the North West. Staff told us that they could access written translated materials for patients if this was required. Patients could access interpreters, either face to face or over the phone depending on the language spoken.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients raised concerns or complaints at the weekly community meeting which took place on each of the wards.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. This information was tracked to ensure it was carried out within the stated timescale, and if there were delays this was explained to the person making the complaint.

Managers investigated complaints and identified themes. Information about complaints, any identified themes or further action was shared and monitored through the governance process. All complaints were reviewed by the hospital director before being closed. There had been 12 complaints in the last 12 months, across all 7 wards. 2 were upheld, 5 were partially upheld, 3 were not upheld, and the remainder were still in progress. There were no overriding themes to these complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service used compliments to learn, celebrate success and improve the quality of care. Information was shared with staff through provider bulletins and in team meetings.

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

Requires Improvement

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

There was a hospital director over the whole hospital who was the registered manager. Staff told us that there had been 5 hospital directors in the last 7 years. The hospital director was supported by a deputy. There had been a major corporate restructure over the last year which had introduced changes and movement amongst staff in management positions. The hospital had 13 wards, including the 7 wards included as part of this inspection. Each ward had a ward manager and deputy. Managers told us they generally felt supported by the senior leadership team. All 13 ward managers were managed and supervised by one person. The hospital had clinical leads for each of the professions, and non-clinical managers for the general management of the building and service.

Staff generally found their local managers supportive and approachable. However, they had mixed views about more senior managers. Some staff were positive about them, but others told us they had no interactions with them, or said that senior managers only visited the wards when there were problems.

Vision and strategy

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

The service's vision and values were on display on the wards, and were incorporated into staff's job descriptions. Staff told us what the values were, and that these were reflected in their work with patients.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff were positive about the culture in the hospital, and felt that teams worked well together and supported one another. None of the patients or staff we spoke with believed there were signs of a closed culture within the hospital. Staff felt they had a voice and were able to raise any concerns they had.

At the last inspection there had been concerns about lower staffing levels and negative cultures on night shifts on some of the wards. Managers acknowledged that maintaining adequate staffing levels was more difficult at night. Work was ongoing to make night staff feel less isolated, and to remove any 'split' between day and night staff. This included rotating staff between day and night shifts, team meetings and reflective practice sessions during the night shift, managers visiting the wards or doing occasional shifts at night, and having a senior nurse on duty at night to provide additional support across the hospital.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

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

Requires Improvement

The provider had a clinical and corporate governance structure for monitoring quality and performance. This included gathering and reviewing information, meetings and committees that reviewed information and took actions, an annual audit schedule, and quality walk rounds by managers. However, although there were governance processes in place, and some actions had been taken, there were still key areas where gaps had not been identified, or had been identified but action had not been taken about them either at all or in a timely manner.

There were requirement notices at the last inspection in April 2022 under well-led. There had been progress in some of these areas, but they had not all been addressed. The service had taken action to improve concerns raised about staffing levels and negative cultures at night. There was now a process for checking equipment which had broadly been implemented, but we did see a gap at ward level. There was still not a robust process for ensuring that all patients have appropriate physical healthcare monitoring carried out; this included after rapid tranquilisation, with regards to women of child-bearing age who are prescribed sodium valproate, and venous thromboembolism (VTE) risk assessments. In response to this inspection the provider produced draft processes for VTE assessment and for medicines reconciliation, but these were yet to be implemented/embedded.

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always review the effects of medicines on each patient's mental and physical health, and it was not always clear that appropriate action was taken in response to this.

There was not sufficient monitoring and oversight the quality of service. There were detailed minutes and action plans from the various meetings across the hospital, and whilst these showed that actions had taken place, action plans did not always include completion dates or confirm that actions had been completed. For example, at the patient safety meeting incidents, complaints and safeguarding concerns were reviewed for the whole hospital. At the January 2023 meeting an issue with physical health training and monitoring was identified. This was highlighted as a significant issue requiring urgent action, but there were still gaps in this area by the time of this inspection. Other documents also included reminders regarding rapid tranquilisation and seclusion paperwork not being completed effectively, but again this was still identified as an issue at this inspection. The clinical action safety plan did show that positive work had been taken to review multidisciplinary team meetings, and asking patients about their experiences. However, we found gaps in care records, which had not been identified as part of any care document review.

Management of risk, issues and performance

Managers maintained a risk register for the hospital, which fed into the corporate risk register. The risks in the register were mostly across the whole site, but some were related to specific wards or following specific incidents. General risks included the maintenance of buildings, staff vacancies, and the impact of COVID-19.

The provider took action to mitigate against the risks and challenges of providing a service in a 19th century listed building, and surrounding estate. However, this did not remove the fact that most of this core service was provided in old buildings that were not consistent with current guidance on the provision of a mental health hospital. The exception to this was Fern ward, which had been built in the last five years.

The provider had processes for managing health and safety within the service. Routine testing was carried out on equipment and utilities. All records were up to date, and there were no significant concerns identified. The service had business continuity plans to support managers and staff to plan for emergencies.

Managers had key performance indicators that they reported on for the service. This was incorporated into a dashboard, which used a traffic light system to indicate if targets had been met or thresholds had been met. The information was for the whole hospital, and not for individual wards or core services.

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

Requires Improvement

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, there was not a robust system for managing information that came from outside the hospital.

Patients' primary care records were digital, but they were supplemented by paper records for recording information such as patient observations and physical health checks. Staff did not have access to a robust and consistent process for receiving and managing patient information that came from outside the hospital and the shared email addresses were not overseen effectively.

Staff generally had access to the information technology they needed to do their work. However, there was an ongoing problem with wifi and mobile phone reception in some areas of the building.

Staff made notifications to external bodies as needed. This included commissioners of services, the local authority safeguarding team and the Care Quality Commission.

Engagement

Managers engaged with commissioners and other care providers to meet the needs of their patients.
Admissions to the acute wards were co-ordinated with the local NHS bed hub on behalf of NHS trusts in the North West. Admissions to the other wards were agreed for individual patients, and could be with trusts from across the country. Staff had regular meetings with the bed hub and with care teams for patients.

Learning, continuous improvement and innovation

The wards were not part of any national accreditation schemes. However, the 3 psychiatric intensive care units were members of a national membership organisation that aimed to promote and develop best practice and improvement in PICUs.

Staff were not participating in any research projects at the time of our inspection.