Woodbourne Priory 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?	Requires Improvement
Are services effective?	Good
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

- Governance processes were not always effective. Managers did not have oversight or take action in line with the providers policy in relation to environmental risk assessments, fire safety and evacuation procedures. We found there was no process in place for managers to ensure that physical health checks were carried out as per national guidance or that medical equipment and devices were in date calibrated and cleaned regularly.
- We found concerns relating to infection prevention and control management, and some of the ward furnishings were not properly maintained within the acute wards. Cleaning records had not been completed in line with the provider's policy. The treatment room on Mulberry Ward was not clean and the fridge used to store specimens was dirty. Clinic rooms were not checked for out of date items regularly.
- We were not assured that if males patients were admitted to the eating disorder service that the service would remain compliant with guidance on mixed sex accommodation. The allocated female lounge could, at times be used by families and carer to visit.
- Within the acute wards and the eating disorder service staff did not maintain the privacy and dignity of patients at all times. In one care plan out of 23 reviewed we found negative and derogatory language which did not promote the patient's dignity. Nine out of ten bedrooms on Aspen ward did not have curtains to maintain patients privacy. Staff walked through patient visit areas which impacted on the privacy or patients and their visitors.
- Managers of the eating disorder service did not ensure that regular team meetings took place to or minutes meetings of the meeting shared in a timely way to discuss the outcomes of incidents or to provide staff with updates regarding ward processes.
- Not all children and young people's care plans were personalised, holistic and recovery orientated. Staff did not always actively involve children and young people or their families and carers in care decisions. We spoke with some children and young people who said they did not feel safe on the ward and that they whilst they were on enhanced support they have managed to hurt themselves. We were concerned as staff did not always follow the providers policy and procedures on the use of enhanced support.
- Not all staff had the required training to ensure that they could meet the needs of the patients in their care.

However:

- The service provided safe care. The majority of the wards seen were safe and clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding. They minimised the use of restrictive practices and followed best practice in anticipating, de-escalating and managing challenging behaviour. It was evident that staff prescribed, administered, recorded and store medicines safely.
- Leaders had a good understanding of the services they managed and could explain clearly how teams worked to provide high quality care. Leaders were visible in the service and approachable for patients and staff.
- 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.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team. Ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Summary of findings

- With the exception of the child and adolescent ward, staff had developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. They actively involved patients and families and carers in care decisions.

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 services improved. We rated them as requires improvement because: • The service did not ensure the privacy of patients. Nine out of ten bedrooms on Aspen ward did not have curtains. This was not subject to individual risk assessment or review. • In one care plan we found negative and derogatory language which did not promote the patient's dignity. • Ward environments were not always clean. We found concerns relating to infection prevention and control management, and some of the ward furnishings were not properly maintained. • We identified concerns with fire safety and evacuation procedures including generic personal emergency evacuation plans, and a lack of documentation available to staff in the event of an evacuation. • The seclusion suite did not have a working intercom. • The service had not made reasonable adjustments for a patient with a diagnosis of autism. • We found that managers and leaders did not have oversight of concerns with ward environments and fire safety and evacuation procedures and had not taken action to address these. However: • Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. • The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Summary of findings

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff followed policy when using restrictive interventions. We found that there was good oversight of the use of restrictive intervention by managers and leaders.
- 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.
- The service had effective systems and processes to safely prescribe, administer, record and store medicines.
- Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.
- Ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- There were effective bed management processes in place. Patients did not have to move wards unless it was for their benefit.
- 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.
- Leaders had a good understanding of the services they managed and could explain clearly how teams worked to provide high quality care. Leaders were visible in the service and approachable for patients and staff.

Child and adolescent mental health wards

Requires Improvement

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

- Staff did not always manage risk well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk harm to themselves or others. Levels of restrictive interventions on Mulberry ward were varaible.

Summary of findings

- The treatment room was not clean and the fridge used to store specimens was dirty. Clinic rooms were not checked for out of date items regularly.
- Not all children and young people's care plans were personalised, holistic and recovery-orientated. Not all staff had access to training to meet the needs of children and young people they were supporting.
- Not all children and young people felt safe on the ward.
- Staff did not always treat children and young people with compassion and kindness, respect their privacy, or understand the individual needs of children and young people. They did not always actively involve children and young people or their families and carers in care decisions.
- The governance processes on the ward did not always operate effectively or provide the right assurances at a team level. Agency induction checklists were not always complete. Staff did not always score children and young people's paediatric early warning score (PEWS) records correctly. Managers did not have sufficient and effective systems and processes to ensure that medical equipment and devices stored in the clinic room were kept in date, calibrated, or cleaned regularly.

However:

- The wards had enough nurses and doctors. They managed medicines safely and followed good practice with respect to safeguarding. Staff provided a range of treatments suitable to the needs of children and young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the ward. 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. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- Leaders had a good understanding of the needs of the children and young people and how to address these as well as a comprehensive understanding of the service they managed.

Substance misuse services

Good

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The clinical premises where clients were seen were safe and clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However:

Summary of findings

- Staff did not always complete observations of physical health, during clients' withdrawal from alcohol, at the frequency specified by the client's consultant.

Specialist eating disorder services

Requires Improvement

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

- Governance processes were not always effective. Managers did not always ensure that environmental risk assessments were updated regularly in line with the provider's policy.
- There was limited space on the ward for therapeutic activities and visits. The lounge area felt cramped when all patients were in this space and staff sometimes had to walk through visiting areas to get to other parts of the ward; impacting on the privacy of patients and their visitors.
- At the time of the inspection, the ward was all female. However, we were not assured that if males patients were admitted there would be a day lounge allocated to females only as per guidance on mixed sex accommodation.
- Whilst we noted that the ward was clean and tidy, there were not cleaning records completed in line with the provider's policy.
- Managers of the eating disorder service did not ensure that regular team meetings took place to or minutes meetings of the meeting shared in a timely way to discuss the outcomes of incidents or to provide staff with updates regarding ward processes.
- Newly employed staff had not completed training specific eating disorder training.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well and they minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of

Summary of findings

treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- 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 Woodbourne Priory Hospital

Woodbourne Priory Hospital is owned by Priory part of Median and is registered to provide care and treatment to children, young people and adults with mental health conditions, including those whose rights are restricted under the Mental Health Act.

The service is registered to provide the following regulated activities:

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

The service had a CQC registered manager in post at the time of the inspection.

The service comprises seven wards:

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

- Maple, Beech and Acer wards are mixed gender acute wards and have 37 beds.
- Aspen Ward a male-only psychiatric intensive care unit and has 10 beds.

Child and Adolescent mental health wards:

- Mulberry Ward a mixed gender inpatient child and adolescent mental health ward with 14 beds.

Specialist mental health eating disorder services:

- Oak Ward a specialist eating disorder ward for adults of working age and has nine beds.

Substance Misuse Service:

- The Manor is a private adult mental health and addiction therapy ward and has nine beds. The Manor also offers an aftercare programme for patients who have completed the inpatient service.

The Care Quality Commission carried out a focussed inspection in May 2022 following the publication of a prevention of future deaths document that was created after the coroners hearing into the death of a service user at the service in September 2020. The overall rating for the service following the inspection was inadequate. The safe and well led domain was inadequate, effective caring and responsive domains were not inspected and remained rated as good. The service had received two requirement notices in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and one in regard to Regulation 17 HSCA (RA) Regulations 2014 Good governance.

This inspection was a comprehensive inspection to see if the provider had met the requirement notices of the last inspection.

What people who use Acute wards for adults of working age and psychiatric intensive care units service say

We spoke with 12 patients and four carers who were positive about the service and described staff as experienced, knowledgeable and non-judgemental. They said that staff treated them with care and compassion and were empathetic to their personal circumstances.

Summary of this inspection

Patients felt safe on the wards and said that staff were friendly and welcoming. They were explained their rights and legal status on admission and at regular intervals afterwards.

Patients were generally complimentary about the range of activities available to them. Some patients felt there could be more activities on weekends.

All patients and carers were aware of the complaints procedure and said staff dealt with complaints in a timely manner. Patients said they had regular one to one time with their named nurse. Patients told us told us that care and treatment were patient-led, personalised and that treatment targeted their individual needs.

Feedback from families and carers about communication was mixed. Some families told us they were unable to get through to the wards by telephone or that staff did not return their calls in a timely manner.

What people who use Child and Adolescent Mental health wards say

We spoke with 3 children and young people and 3 carers.

Not all children and young people we spoke with felt safe on the ward and staff did not carry out their enhanced observations properly which meant they were able to self-harm.

One young person told us staff were not managing prohibited items being brought onto the ward from leave and not effectively searching other young people. Some children and young people told us staff bring in and use restricted items on the ward such as their mobile phones.

Children and young people also told us that the food was not great.

Most children and young people told us regular staff were caring and understanding, the advocacy service had improved and the education provision was good. However, temporary staff did not understand their needs, engage with them and were not respectful or show empathy.

Carers did not always feel involved in their relative's care or treatment.

What people who use the Substance Misuse services say

Clients gave very positive feedback about the staff. They said they were very supportive and keen to help them. Clients felt confident that they could approach members of staff at any time for help and support.

What people who use the Specialist Eating Disorder services say

We spoke with three patients and five carers during this inspection. All three patients were complimentary about staff and told us that they were kind, caring and available to support them when needed. Patients told us that they understood their care and treatment and had some involvement in creating their care plan, however one patient told us that they felt they could have had more meaningful involvement with this.

Summary of this inspection

All three patients told us that the number of rooms for therapy and visits on the ward was limited. All patients spent a period of time in the lounge after mealtimes, so they could be supervised by staff. One patient told us that the lounge was small and felt cramped when all patents were in there. Two patients and one carer told us that the room that was used for visits was not private as staff sometimes walked through to get to other areas of the ward.

Both patients and carers raised concerns about the quality of the food on the ward. Three carers told us that they felt some meal options were unhealthy and not very nutritious. We saw that patients had also regularly raised concerns about food with staff during weekly community meetings.

All five carers we spoke with told us that they had been invited to attend meetings about their family member's care and treatment. Three carers told us that they had experienced some issues with their level of involvement in these meetings but had been able to discuss their concerns directly with the ward manager, who they described as approachable and dedicated.

How we carried out this inspection

How we carried out this inspection

The inspection team visited Oak ward, Manor ward at Woodbourne Priory hospital on 10 January 2023.

The inspection team visit the four acute and PICU wards on 17 and 18 January 2023.

The inspection team visited Mulberry ward on 24 and 25 January 2023.

For this inspection we reviewed all the key lines of enquiry; safe, effective, caring, responsive and well led. During the inspection we:

- looked at the layout and environment of all wards including clinic rooms;
- spoke with 47 including nurses, health care assistants, doctors, therapy staff, housekeeping staff, and senior leaders;
- reviewed 43 care records;
- reviewed section 17 leave forms and observations records 8 patients;
- reviewed 4 prescription chart;
- spoke with 15 patients, 3 clients and 3 children and young people;
- reviewed 10 children and young people's paediatric early warning score (PEWS) records
- spoke with 12 carers;
- observed multidisciplinary meetings, daily 'flash' meetings, a professional meetings and patients community meeting;
- conducted observations in communal areas;
- Looked at a range of documentation including policies, staffing data, audits, meeting minutes and quality improvement tools.

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.

Summary of this inspection

Specialised Eating Disorder Services

Action the service MUST take to improve:

- The service must ensure that there is an effective process in place to ensure staff are updating environmental risk assessments regularly and after any incident, in line with the provider's policy (Regulation 17(1)).
- The service must ensure that cleaning records are completed and kept up to date, in line with the provider's policy (Regulation 17(1)).
- The service must ensure that team meetings occur regularly to ensure staff have opportunities to discuss the outcomes of incidents and for managers to provide updates regarding any changes in ward processes (Regulation 17(1)).
- The service must ensure that a day lounge is allocated solely for use by women who do not wish to sit in communal areas (Regulation 10 (2))

Action the service SHOULD take to improve:

- The service should continue to ensure that it maintains safe staffing levels on Oak ward to keep people safe from harm (Regulation 18(1)).
- The service should ensure that staff can access training specific to working with those with eating disorders (Regulation 18 (1)).
- The service should ensure that staff respect and maintain patient's privacy during visits (Regulation 9(1)).
- The service should ensure that patients can have meaningful input into their care plan.
- The service should ensure that patients have access to regular meaningful activities, including at weekends.

Child and Adolescent Mental Health Wards

Action the service MUST take to improve:

- The service must ensure the treatment room and specimen fridge is clean, they are checked for out of date items and items in the clinic room are calibrated regularly and this is documented. (Regulation 12(1)).
- The service must ensure staff follow the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk of harm to themselves or others. (Regulation 12(1)).
- The service must ensure all staff have access to, and regularly update all copies of children and young people's care plans and risk assessments and staff have read these. (Regulation 12(1)).
- Managers must ensure staff review and take appropriate action with regards to children and young people's paediatric early warning score (PEWS) records and escalate concerns where necessary following the providers guidance and managers must ensure staff score children and young people's paediatric early warning score (PEWS) records correctly. (Regulation 12(1)).
- Managers must ensure agency induction checklists are fully complete. (Regulation 17(1)).
- Managers must ensure they have sufficient and effective systems and processes to ensure that medical equipment and devices stored in the clinic room are kept in date, calibrated and cleaned regularly. (Regulation 17(1)).

Action the service SHOULD take to improve:

- The service should ensure they continue to reduce the use of bank and agency staff.
- The service should ensure bank staff keep up to date with their mandatory training.
- The service should ensure staff record children and young people's 1 to 1 sessions with their named nurse.
- The service should ensure staff have access to and know where handover paperwork is prior to it being filed.

Summary of this inspection

- The service should ensure all staff have access to specialist training to meet the needs of children and young people.
- The service should ensure it involves and provides specific advice to children, young people and carers about their medicines.
- The service should ensure staff treat children and young people with compassion, kindness, respect their privacy and support them to understand and manage their care, treatment or condition.
- Managers should ensure restricted items are kept off the ward and not used by staff.
- The service should ensure staff follow the providers policy and procedures to maintain children and young people's confidentiality.
- The service should ensure they involve children and young people and give them access to their care planning and risk assessments.
- The service should ensure children and young people are happy with the food available on the ward.

Substance Misuse Services

Action the service SHOULD take to improve:

- The service should ensure that physical health checks of clients are carried out in accordance with the doctor's instructions.
- The service should consider introducing a standard tool for assessing the severity of alcohol dependency.
- The service should consider fitting a self-locking mechanism on the door of the clinic room.
- The service should ensure checks of controlled drugs take place in accordance with the hospital's policy.

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

Action the service MUST take to improve:

- The service must ensure the privacy and dignity of patients, including ensuring all bedroom windows have curtains, unless there is a clear risk-based rationale why these are not in place (Regulation 10(2))
- The service must ensure that care plans contain appropriate language and are written in a way which promotes patient's dignity. (Regulation 10(1))
- The service must ensure that ward environments are clean and adhere to infection prevention and control standards and guidance. (Regulation 12(2))
- The service must ensure that there are robust fire safety and evacuation procedures in place including up to date and individualised personal emergency evacuation plans. The service should also ensure that staff have access to appropriate documents in the event of an evacuation. (Regulation 12(2))
- The service must ensure that the design, layout, and furnishings of wards are properly maintained. (Regulation 15(1))
- The service must ensure that the seclusion suite intercom is fixed in order to support patients to communicate effectively with staff. (Regulation 15(1))
- The service must ensure that it makes reasonable adjustments for patients with a diagnosis of autism. This must include ensuring appropriate care plans are in place and sensory and dietary needs are met. (Regulation 9(3))
- The service must ensure that leaders and managers have oversight of, and act on concerns regarding ward environments, and fire safety and evacuation procedures. (Regulation 17(2))

Action the service SHOULD take to improve:

- The service should ensure good communication with family and carers and that they are able to contact the wards by telephone or email in a timely manner.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Child and adolescent mental health wards	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement
Substance misuse services	Good	Good	Good	Good	Good	Good
Specialist eating disorder services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

Wards were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. This included risk assessments of bedrooms, outdoor spaces and communal areas. The environmental and ligature risk assessments we reviewed had been updated within the last 12 months. Staff knew about potential ligature anchor points and could describe how they mitigated the risks to keep patients safe. Managers kept hard copies of ligature risk assessments on wards and these were readily available to all staff. All new starters received training and information about ligature points during their induction.

However, we found concerns with fire safety procedures and documentation. We reviewed all personal emergency evacuation plans (PEEPs) for patients on Acer, Beech and Maple wards. On Acer ward we saw that these were generic and had not been individualised. The PEEPs did not specify whether patients were detained under the MHA and their level of risk. It was not clear how staff would identify or manage risk in the event of an evacuation. The PEEPs also did not set out instructions on how to safely escort patients from the building.

On Acer ward staff had not removed a PEEP from the file, despite the patient being discharged five days previously, and on Maple ward, one patient did not have a PEEP despite them being admitted in October 2022 and having identified risks of vandalism and suicidal ideation. We were concerned this could place staff, patients and the Fire Service at risk in the event of an emergency.

The contents of fire safety grab bags varied across the wards. The grab bag on Maple ward contained a Fire Safety and Evacuation Procedure that wasn't specific to the ward. In addition, this document did not specify a review date, and did not appear to have been reviewed since February 2015. The grab bag on Beech ward contained a fire blanket and did not contain any PEEPs or a plan of the building layout. The ward manager told us that both PEEPs and building layout plans remained in the office in the event of an evacuation and staff wouldn't have access to these once outside.

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

Requires Improvement

Staff could observe patients in most parts of the wards. There was a blind spot at the entrance to Maple ward. This was recorded on a risk assessment and there was CCTV in the area which could be viewed from the nursing office. Blind spots that had been identified in previous inspections had all been mitigated.

The ward complied with guidance on same sex accommodation. Acer, Maple and Beech wards were mixed sex wards. All sleeping and bathroom areas were segregated, and patients did not have to walk through areas occupied by another sex to reach toilets or bathrooms. There were separate male and female toilets and bathrooms, and each ward had a female lounge.

Staff had easy access to alarms and patients had easy access to nurse call systems. Additional alarms were available, and managers could request these from other wards where required.

Maintenance, cleanliness and infection control

Ward areas were not always clean, well maintained, well-furnished or fit for purpose. Whilst cleaning records showed they were up-to-date, we found that the laundry room on Aspen ward had a strong and unpleasant damp smell.

Whilst there was a system in place to identify clean and dirty laundry it did not appear to be effective. We found that work surfaces in the laundry were covered with clothes and bags of clothes, it was unclear whose clothes belonged too. A blue laundry bag for non-soiled clothes on Acer ward was heavily stained. Although, we acknowledged that patients had not reported any concerns about their laundry.

The chairs within the extra care area on Aspen ward were visibly dirty, and there was staining underneath.

Staff had access to handwashing gel and personal protective equipment. We observed staff handwashing throughout the inspection, including in clinic rooms and when entering or exiting wards. Wards maintained infection prevention and control audits and those we saw were detailed and up to date

Seclusion room

The Seclusion room had a toilet and clock and allowed clear observation. However, the intercom was not working. It was not clear how long this had been broken for, and managers told us there was no record of ward staff reporting this issue to maintenance prior to them becoming aware. Managers had added this to the service risk register in December 2022. The maintenance team did attempt to fix the intercom unfortunately without success. Staff reported this to the specialist contractors and were awaiting confirmation of a date for them to complete the work.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment. This included weekly checks completed by pharmacists.

Safe staffing

The service 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 had enough nursing and support staff to keep patients safe, although wards had nursing and health care assistant vacancies. On Aspen ward, 5.85 out of 30.9 full time equivalent posts were vacant. Acer ward had 3.72 vacant posts out of 19.4. Beech ward had 6.29 out of 28.7 vacant posts. For Maple ward this was 4.74 out of 37.5 posts.

We reviewed a sample of staffing rotas and saw that the service had reducing rates of agency staff. For example, on Maple ward, 31 agency staff worked on the ward during a one- week period in October 2022. By January 2023 this had reduced to 12 agency staff used during one week. Managers told us they had undertaken a recruitment drive throughout the previous six months and spoke positively about having more regular staff who knew the service and patients.

Managers limited their use of bank and agency staff and requested staff familiar with the service. A review of staffing data for Maple ward showed that during the week of the inspection six out of 12 agency staff on the current rota regularly worked on the ward.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. The annual turnover was 2.1%. Levels of sickness were low. Data provided by the service showed that the annual sickness rate was 5.3%

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift and there was a standardised form staff used to enabled do so. Staffing numbers were calculated based on observation levels and patient risk.

The ward manager could adjust staffing levels according to the needs of the patients and additional staff were utilised to ensure patient observations were completed. In the three months prior to the inspection, there had been no shifts that were short staffed.

Patients had regular one to one sessions with their named nurse and care records showed that nurses routinely documented when they spent time with patients and provided summaries.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The patients we spoke with told us they could access their leave regularly.

The service had enough staff on each shift to carry out any physical interventions safely.

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

included during handovers, discharge meetings, and multidisciplinary team meetings.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Each ward had a permanent consultant psychiatrist and speciality doctor. Two of the specialty doctors were employed on a locum basis.

Managers could call locums when they needed additional medical cover. Out of hours cover arrangements were in place and the service had an on-call system embedded that they used in emergencies.

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

Requires Improvement

Mandatory training

There was a process in place for managers to monitor mandatory training and alert staff when they needed to update their training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training modules included safeguarding adults and children up to level three, manual handling, Intermediate Life Support, Basic Life Support, training in the Mental Capacity Act and The Mental Health Act and equality and diversity training.

Staff completed and kept up to date with their mandatory training. Statutory and mandatory training compliance for the previous 12 months was 88% overall. Training compliance was: 95% Acer ward, 88% Aspen ward, 88% Maple ward, and 86% Beech ward. Wards had compliance of over 75% for all training module, with the exception of Beech ward and Aspen ward who were at 65% and 75% respectively for reducing restrictive interventions training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well 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 for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

At the previous inspection we found the approach to updating risk assessments and care plans to be inconsistent. Managers and leaders had taken action to address this and there were standardised procedures in place to ensure that staff updated risk assessments and care plans in a timely manner.

We reviewed a total of 25 care records and saw that care plans and risk assessments were reflective of current risk levels. Recent incidents or changes in risk level were flagged and discussed during daily flash meetings and staff were prompted to updated risk assessments and care plans to reflect these changes. This meant that staff working with patients were aware of the risks that the patients could pose to themselves and others, and enabled them to mitigate against such risks.

Significant incidents of risk were reviewed in a timely manner by a senior clinician and there was early communication of the incident and immediate actions, such as raising observation levels, at ward handover.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Risk assessments were comprehensive and regularly reviewed and updated.

Staff completed risk assessments prior to patients accessing leave. This included assessing patients' mental state and current presentation and reviewing daily entries in care records. Staff also recorded details for contact and identification if the patient did not return from leave as planned.

Staff we spoke with understood the process around leave and knew how to report a patient not returning on time or absconding if escorted.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The policy provided guidance for different types of searches and directed staff to assess when searches were required, how to complete these, and how to record that they had searched a patient.

Though we did see some blanket restrictions on the wards in terms of access to hot drinks and the restrictions of some high risk items, these had been risk assessed and were appropriate. There were no blanket restrictions in place that were not justified.

Use of restrictive interventions

Levels of restrictive interventions were low. Data provided by the service showed that in the previous six months restraint had been used 39 times on Aspen ward. This figure was 35 and 30 for Beech ward and Maple ward respectively. Acer ward had not used restraint during this period.

The service provided seclusion data which showed that Aspen ward had used seclusion 31 times during the previous six months. Beech ward had used seclusion twice. Maple ward and Acer ward had not used seclusion during that period.

We found that there was good oversight of restrictive intervention use. Staff submitted incident reports each time restrictive interventions were used. Managers were notified of these and ensured these were flagged for discussion during multidisciplinary team reviews. The compliance team collated restrictive interventions data for each ward, which managers and leaders reviewed during monthly risk management meetings.

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

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

Staff followed NICE guidance when using rapid tranquilisation and completed observations appropriately after using this. The service used an external pharmacy service and the pharmacist monitored rapid tranquilisation use. There was a centralised auditing process for rapid tranquilisation and staff and managers discussed data in monthly acute service line meetings. All clinical staff received training on rapid tranquilisation. Senior leaders also shared information on rapid tranquilisation during weekly cascade meetings.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff recorded the reason for seclusion and completed nursing and medical reviews as per organisational policy and in line with national; guidance. Multidisciplinary and independent reviews of seclusion took place in line with MHA Code of Practice guidelines. Patients in seclusion had seclusion care plans.

Staff had access to guidance in the Mental Health Act Code of Practice for long-term segregation, but no patients had been placed in long term segregation during the previous six months.

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. Staff kept up-to-date with their safeguarding training. Training compliance for safeguarding adults and children training was 84% Maple ward, 95% Beech ward, 82% Aspen ward, 100% Acer ward. Training was given up to level three for ward staff

There was a standardised process for reporting safeguarding concerns. Staff completed internal alerts, which were assigned to dedicated safeguarding leads. Safeguarding leads then investigated these and determined whether safeguarding referrals to the local authority were required.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Data provided by the service showed that there were 26 open safeguarding referrals at the time of inspection. We reviewed a sample of these and saw good communication with local authorities. Safeguarding leads work with external staff to develop action plans, discuss new referrals and share learning.

There was evidence that managers and leaders identified and shared learning as a result of

safeguarding referrals. This included implementing measures to protect patients at risk of being exploited by others.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Managers gave updates to staff about how to support non-binary and transgender patients. There was information on wards about religious faiths, and managers described how they tried to promote awareness and acceptance of patient's beliefs.

Staff followed clear procedures to keep children visiting the ward safe. Visiting rooms were secure and separate from wards. Where visits involving children took place within the unit, these were risk assessed and supervised by staff if this was assessed as necessary.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Documents were password protected and the trust allocated staff log in accounts to ensure they could access and update care records.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. There was an electronic prescribing system in place which staff spoke positively about.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

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

Requires Improvement

Staff completed medicines records accurately and kept them up-to-date. We reviewed 26 prescriptions. These were signed and dated, and staff correctly recorded medication doses and amounts. Staff reviewed pro re nata medication (PRN medication, which is medication that is given when required) every 14 days as a minimum and took action where required. Staff recorded patient's allergies within their prescriptions.

Staff stored and managed all medicines and prescribing documents safely. They completed daily stock checks of medicines and fridge and room temperatures. Pharmacists completed audits to monitor that these had taken place and developed actions following these which staff resolved.

Staff disposed of medicines safely using designated disposal bins and all medicines disposed of were recorded within the clinic room audit.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Pharmacists produced twice weekly reports containing themes and trends and flagged any increases in medicines use. These were discussed with medical staff individually and during clinical governance meetings.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. This included monitoring the duration of use.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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 we spoke with knew what incidents to report and how to report them. Staff received training in how to use the service's incident reporting system.

Staff raised concerns and reported incidents and near misses in line with provider policy. The reporting system prompted staff to grade, categorise and provide a description of the incident. Staff also recorded post incident action taken.

Staff reported serious incidents clearly and in line with trust policy. This included completing initial 24- and 72-hour reports of the incident, and referring to policy guidance to determine whether a serious incident investigation was required. The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The incident report process prompted staff to apologise to patients, family or carers where necessary. The records we reviewed showed that staff routinely recorded when they had done so.

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

Requires Improvement

Managers debriefed and supported staff after any serious incident and used a standardised document to record that a debrief had taken place. We reviewed a sample of debriefs and saw that staff had the opportunity to feedback on the incident, and discuss lessons learned.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. On-call managers reviewed incidents five days per week and produced incident reports and summaries which were circulated to ward managers.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers logged emails containing learning they had circulated to staff. Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, managers described how they had met with a patient post incident and had implemented changes to their care plan and observations to improve care and reduce the risk of similar incidents.

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. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a mental health assessment of each patient either on admission or soon after. Care records showed that patients routinely had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. There were different care plans in place for different care needs. Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery orientated. Staff worked with patients to develop activities of daily living in preparation for discharge including cleaning, cooking and finance management. Care plans documented patients' views or wishes. We saw from care records and speaking with staff and patients that staff offered patients copies of their care plans and recorded that they had done so, although some patients told us they had not been offered copies of these.

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. They also participated in clinical audit, benchmarking and quality improvement initiatives.

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

Requires Improvement

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. Managers shared National Institute for Health and Care Excellence (NICE) guidelines and updates with staff regularly through team meetings and handovers or circulated this via email. Staff also had access to 'live view' , an online resource which contained links to relevant guidelines including NICE guidelines

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. This included referrals to dental surgeries, opticians and GP practices.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included implementing daily planners to help support good sleep hygiene and healthy eating.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff took part in benchmarking and quality improvement initiatives. Leaders had recently implemented a standard operating procedure to ensure that staff triangulated incident reports with risk assessments, care plan and clinical notes. This was put in place to ensure the multidisciplinary team were aware of current risks and that documentation reflected this.

Managers used results from audits to make improvements. We saw that audits were used to evaluate the quality of care delivered. There was a system in place to ensure audits were issued centrally to enable staff to complete these in good time. Divisional leads set the content and signed off audits. They also oversaw audit analysis and divisional learning and ensured audit action plans were developed and reviewed. Managers and leaders reviewed audit action plans during clinical governance committees.

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 range of specialists to meet the needs of the patients on the ward. All wards had access to occupational therapists, occupational therapy assistants, psychologists and psychology assistants, although some therapy posts were vacant at the time of inspection. 2 of the 4 occupational therapy posts were vacant. 1.6 out of 4 psychology posts were also vacant. Some staff felt there could be more activities at weekends. However, patient feedback on the range of activities available was overall positive.

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. This included a three- day office-based induction followed by shadowing shifts for two weeks prior to sign off. Inductions included ward orientation, and an overview of ligature points and blind spots. New starters were also given information on banned and restricted items and signposted to organisational policies and mandatory training. We reviewed a sample of induction checklists and saw these were fully completed and signed off by managers.

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

Requires Improvement

Managers supported staff through regular, constructive appraisals of their work. The appraisal compliance rate for the previous 12 months was 100%. Managers used one-to-one sessions and the annual appraisal system to identify learning and development needs for staff.

Managers also supported staff through regular, constructive managerial and clinical supervision of their work. Data provided for the previous six months showed that an average of 86% of staff received monthly supervision. This figure included staff on long sickness and maternity leave. Where staff were unable to attend supervision sessions, managers documented this in a supervision log and took steps to re-arrange these.

Managers made sure staff attended regular team meetings. In some cases, team meetings had low attendance from nurses, and managers described how it was sometimes difficult for nurses to take time away from wards to attend. Nevertheless, managers gave information to those who could not attend through handovers and circulated meeting minutes to all staff. Team meetings followed a standardised agenda which included a review of patient and carer feedback, incidents and lessons learned, complaints and compliments, and regional and divisional updates.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

They made sure staff received any specialist training for their role, including in leadership, phlebotomy, and courses to certify as management of violence and aggression trainers.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers we spoke with could describe the processes for performance management of staff if required. This included implementing action plans to improve clinical skills or provide staff with support to help them manage patient interactions.

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. We reviewed a sample of multidisciplinary team meeting minutes and saw that these took place weekly for each patient and were well attended by staff from a range of disciplines.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff recorded and shared information regarding patient risk, care plan reviews and funding/ placement updates.

Ward teams had effective working relationships with other teams in the organisation. This included regular liaison with the compliance team to discuss training and supervision compliance, incident reports, key performance indicators, and to plan quality reviews of the service.

Ward teams had effective working relationships with external teams and organisations. External staff including social workers, discharge coordinators and independent mental health advocates attended multidisciplinary team meetings. Managers said it was sometimes difficult for external staff to attend meetings, but that they encouraged this through remote video calls to make it easier for them to attend.

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

Requires Improvement

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 guiding principles. Training compliance for the service was 92% Acer ward, 95% Aspen ward, 94% Beech ward, 100% Beech ward. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There were copies of the Code of Practice available on wards.

Staff knew who their Mental Health Act administrators were and when to ask them for support. The administrator visited wards daily to collect Mental Health Act paperwork.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw information on display on the wards about how to contact the independent mental health advocate. Managers compiled quarterly advocacy monitoring reports containing data on the number advocacy referrals, interventions and themes, and patient feedback about advocacy support.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. There was a process embedded to remind staff when patient rights needed to be revisited and the frequency of this was determined individually.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to and in a timely manner. There were T3 certificates of second opinion on file where required.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. This included making electronic copies of detention papers and keeping copies of medication authorisation certificates with prescription charts.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. These included auditing treatment certificates, detention papers, and sectioned patients' rights. The service also audited the number of appeals against detention patients made to the First Tier Tribunal and independent hospital managers.

Managers displayed good oversight of the Mental Health Act and used visual display boards in the nursing office to record patients' detention status, expiry dates, and leave arrangements.

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

Requires Improvement

Good practice in applying the Mental Capacity Act

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

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. Training compliance was 90% Maple ward, 82.5% Beech ward, 87% Aspen ward and 100% Acer ward.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards and told us they would contact the Mental health legislation administrator.

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 clearly 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. The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. However, they did not always understand the individual needs of patients.

Staff were discreet, respectful, and responsive when caring for patients. Patients were overall complimentary about staff and said they found staff to be approachable and supportive. Patients visited the clinic room individually to receive their medications to ensure their privacy was maintained.

Staff gave patients help, emotional support and advice when they needed it. Care notes documented staff spent regular one to one time with patients.

Staff supported patients to understand and manage their own care, treatment or condition. This included providing advice on medication and its side effects.

Staff directed patients to other services and supported them to access those services if they needed help. Wards had information boards giving information on how to contact independent mental health advocates and community teams.

However, staff did not always understand and respect the individual needs of each patient. There were two patients on Maple ward who had a diagnosis of autism. Staff we spoke with were unaware of this. We reviewed the most recent care and treatment review for one of these patients which found that the ward had not made the appropriate reasonable adjustments. For example, staff had not implemented an autistic spectrum disorder care plan or positive behavioural support plan. There was no sensory integration passport, autism profile or sensory diet in place. These concerns had been identified during a Care and Treatment Review in November 2022, but staff had not acted on this.

We also found concerns with the use of derogatory or negative language in one care plan on Aspen ward out of the 23 we reviewed. The plan described the patient as "stinking" and staff recorded that "their personal hygiene" didn't look good". We were concerned about the use of language and the impact on the patient if had they read this.

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

Involvement in care

Staff involved patients in care planning and risk assessment. Staff 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 and services as part of their admission. Staff gave patients admission packs with relevant information.

Staff involved patients and gave them access to their care plans and risk assessments. There was space within the notes to record whether care plans were offered to patients and staff routinely completed this

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Patients told us they had an opportunity in ward round meetings to ask questions and to discuss care and treatment and discharge plans. Medication leaflets were offered in easy read formats if required. A patient whose first language was not English also told us they had received information about their care and treatment in their first language.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment, and staff supported them to do this. Wards had weekly community meetings and managers made changes in response to feedback. This included buying new ward equipment and activities including a sensory board. They also provided patients with access to online streaming services and media devices. Managers displayed action they had taken on 'you said, we did' boards which were displayed in patient areas. Patient feedback was an agenda item in governance meetings.

Staff made sure patients could access advocacy services. Patients understood advocacy support was available. Most patients we spoke with were using the advocacy service and managers kept a log of this.

Involvement of families and carers

Staff mostly informed and involved families and carers appropriately.

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

Requires Improvement

Staff did not always support, inform and involve families or carers. Designated carer leads were in place to liaise with family and carers to provide patient updates and seek feedback. However, the impact of this varied across the wards. Some families and carers reported consistent feedback from staff. However, others told us that staff did not always return their calls. Staff invited families and carers to ward rounds with patient consent. Family and carers spoke positively about wards rounds and found these were useful for receiving updates on patient care.

Staff helped families to give feedback on the service. Managers kept a log of compliments, complaints and feedback from carers. One family member who had made a complaint told us it had been dealt with effectively and in a timely manner

Is the service responsive?

Requires Improvement

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

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 have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients ensure they did not stay longer than they needed to. There were daily meetings with commissioners to discuss admissions and discharges. Data for the three months prior to the inspection showed that the average length of stay was between 67 and 69 days across the 4 wards.

Managers and staff worked to make sure they did not discharge patients before they were ready. Clinical records showed good communication between nursing staff and medical staff to discuss pending discharges. The records we reviewed contained discharge plans and evidence that discharge planning was considered at an early stage

The service had low out-of-area placements. Admissions were usually planned and commissioned by the local team.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Patients nearly ready for discharge normally transferred to Acer ward, which acted as a step-down unit for transfer or discharge. Following our last inspection, we raised concerns regarding patients being admitted to this ward directly from the community without thorough risk assessment. During the current inspection we found that patients were admitted form outside the hospital and transferred to this ward from other wards within the unit. To support this the services care model had been adapted to support this. When it was necessary to transfer patients from the psychiatric intensive care unit to Acer ward, managers ensured a full multidisciplinary team handover took place to agree that the risks were suitably low and could be manage effectively.

Staff did not move or discharge patients at night or very early in the morning wherever possible. The psychiatric intensive care unit (PICU) was for male patients and was regularly full. If the unit was full or a female patient required PICU bed then referrals were made through the services central system to locate a bed for the patient.

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

Requires Improvement

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. They attended daily meetings with commissioners to discuss discharge barriers and agree actions. Discharges were also discussed during weekly operational meetings and delayed discharge professionals' meetings. We reviewed a sample of meeting minutes and saw that staff were proactively seeking to facilitate timely discharge. There were weekly 'movement' meetings in place to discuss internal transfers between wards.

There was evidence that staff considered the least restrictive option with regards to discharge. For example, staff had arranged for temporary supported living for a patient until permanent accommodation could be finalised to enable them to leave hospital.

Patients were involved in discharge planning and staff documented patients views and wishes about discharge within their care records. We observed discussions between medical and nursing staff during the inspection about patients' wishes and preferences for discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff prepared detailed handovers which included summaries of recent care records, current medication and risk assessments.

The service followed national standards for transfer. Managers received monthly delayed discharge data and arranged professionals' meetings to discuss individual cases.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, and we found concerns with communal areas and bedrooms which impacted privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Some patients chose to display posters or daily plans on their walls or to decorate their rooms. However, on Aspen ward nine out of ten bedrooms did not currently have curtains. There were magnetic anti- ligature fittings in place to enable these to be safely attached to the wall. Staff told us these had most likely been pulled down by patients or removed due to patient risk. However, there were no risk assessments in place to document whether curtained needed to be removed or what the rationale was. Staff later told us it was likely they had forgotten to put these back up and usually only put them up when patients asked them to do so. We were concerned regarding the impact this could have on patients' privacy and dignity.

Patients had a secure place to store personal possessions. Bedrooms contained lockable storage facilities and there were secure cabinets to store banned and restricted items which staff risk assessed and returned to patients when they left the wards. Staff maintained a log of these items which they reviewed during each ward round.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had meeting rooms, quiet areas, activity rooms, day rooms and a clinic room.

The service had quiet areas and a room where patients could meet with visitors in private. On Acer ward, family and friends could visit the ward. Maple, Beech and Aspen ward, had rooms where patients could meet with visitors in private.

Patients could make phone calls in private and there were cordless phones available to patients. Wards had outside space that patients could access easily. Patients on Aspen ward could make hot drinks and snacks at any time. Whilst the psychiatric intensive care unit kitchen had restricted access for patients due to their individual risks. Staff supported these patients to access drinks and snacks.

The service offered a variety of good quality food. There was evidence that staff acted on feedback from patients regarding the food. This included providing more fruit, more healthy options, and making a wider selection of meals available at weekends.

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, and supported patients to volunteer in the community.

Staff helped patients to stay in contact with families and carers. Most patients had a phone or tablet and ward computers had video calling facilities.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of 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 needs or other specific needs. Wards had disabled access and accessible bathrooms rooms.

There were information boards on all wards to ensure patients could access information on treatment, local services, their rights and how to complain.

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.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included providing vegan and halal options.

Patients had access to spiritual, religious and cultural support. There were copies of religious texts on wards and posters on display sharing information about different faiths and religious groups. Patients within the service had diverse cultural and religious backgrounds and staff described a culture of inclusion and acceptance of others' beliefs.

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.

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

Requires Improvement

Staff understood the policy on complaints and knew how to handle them. At the time of inspection there were 7 open complaints. During the previous 12 months there had been a total of 33 complaints, seven of which had not been upheld, and a further seven that had been withdrawn. None of the complaints had progressed to an independent review by the Parliamentary Health Service Ombudsman. We reviewed a sample of complaints and saw that there was a robust process in place for the investigation and managing complaints. Managers acknowledged complaints in a timely manner and gave patients feedback from managers the investigation into their complaint.

Managers investigated complaints and identified themes. They shared feedback from complaints with staff during team meetings and handovers and through emails. This enabled learning to be used to improve the service.

Managers kept logs of compliments and used compliments to learn, celebrate success and improve the quality of care. They displayed positive feedback on wards and circulated compliments to staff.

Is the service well-led?

Requires Improvement

Our rating of responsive improved. We rated it as requires improvement.

WELL-LED

Leadership

Leaders were visible in the service and approachable for patients and staff. We saw evidence of senior leader presence at ward meetings and patient community meetings.

Most staff spoke positively about senior leaders and told us they received lots of support from both their immediate managers and the senior leadership team. Nearly all staff we spoke with felt able to approach leaders to seek advice or raise concerns.

All wards had weekly timetables which detailed the availability of the senior leadership team, medical staff, ward managers and non-clinical managers. This meant staff knew when and who they could contact for support.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff could train to become infection prevention and control leads, safeguarding leads, or patient safety leads.

Vision and strategy

Most staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Staff described the organisational value of 'putting people first' and how they obtained patient's views and feedback informally and through different meetings and forums. Staff also spoke about the 'being positive' value and how they had showed resilience when caring for patients with complex needs.

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

Requires Improvement

Managers could request additional funding from leaders for equipment or for therapeutic activities and said they felt able to do so. Staff knew who controlled budgets and who to make requests to for equipment.

Culture

Staff felt respected, supported and valued. They felt positive and proud about working for the provider and their team.

Staff we spoke with felt able to raise concerns without fear of retribution. They knew how to use the whistle-blowing process. There was guidance on the intranet and posters on display on wards reminding staff how to do so.

Managers dealt with poor staff performance when needed. There was a standardised process in place which managers used for performance management.

Staff appraisals included conversations about career development and how it could be supported. There were opportunities for health care assistants to complete their nursing training.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

Governance

There were systems and procedures to ensure there were enough staff, that staff were trained and supervised, and that patients were assessed and received appropriate care and treatment. Leaders had oversight of bed management, ensured that discharges were planned, and that incidents were reported, investigated and learnt from.

There were clear frameworks of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviewing incidents, complaints and safeguarding alerts at the service level.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Whilst there was good communication between ward staff, managers and senior leaders, some of the environmental concerns on the wards had not been dealt with effectively. For example, it was not clear what action managers or leaders had taken to ensure patients bedrooms had curtains, or whether senior leaders were aware of this. We were also concerned that the seclusion room intercom had not been working for some time. Whilst managers had taken action if had not resulted in the intercom being fixed.

Management of risk, issues and performance

We found concerns with the fire safety and evacuation procedures within the wards. It was not clear what oversight senior leaders had of these issues.

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

Requires Improvement

Organisational risks were recorded on the risk register. Staff concerns and issues identified through the inspection matched those on the risk register. Individual risks were graded and had designated owners. Managers recorded mitigation controls to manage risks. Managers reviewed risk registers periodically during clinical governance meetings.

Staff maintained and had access to the risk register at ward or directorate level and could escalate concerns when required.

Information Management

The service used standardised systems to collect data from wards and directorates. Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff and managers had access to the equipment they needed to record and maintain care records. Information governance systems included confidentiality of patient records.

Managers had access to information to support them with their roles. This included information on the performance of the service, staffing data and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. Patients and staff could meet with members of the provider's senior leadership team to give feedback.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Managers had a good understanding of incident themes and trends and could give examples of how they had made improvements. For example, following a recent increase in the number of tailgating incidents (tailgating describes how patients follow members of staff out of the ward with a view to absconding) we saw that managers had displayed posters about this on the wards, and circulated emails to staff about this risk. We observed staff checking doors when entering and exiting wards.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, they described how they had fed back regarding the electronic recording system and how managers had acted on this feedback to improve the system.

There were standardised meetings and forums to enable managers and leaders to share learning from incidents and identify good practice.

The service used quality improvement methodologies to record action plans and monitor progress.

There was an effective clinical audit programme in place.

Requires Improvement

Child and adolescent mental health wards

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

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

The clinic and treatment room on the ward was not clean. However, the ward was safe, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. A staff member who was responsible for carrying out checks in relation to health and safety of the ward was clearly allocated each day. Staff members were not identified for this role at our previous inspection so this is an improvement.

Staff could observe children and young people in all parts of the wards and any blind spots were mitigated by risk assessments or additional staffing.

The ward provided mixed sex accommodation, but measures were taken to ensure the privacy and dignity of all children and young people was maintained. Each young person had an en-suite bedroom. This met the same sex accommodation guidance.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe by individually risk assessing children and young people. We saw a 'ligature heat map' showing hot spots staff had to be aware of on the office wall.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. During our visit we saw these systems operating effectively.

Maintenance, cleanliness and infection control

The treatment room was not clean. We found 2 kidney dishes with an unknown fluid in them and used swabs stored in a cupboard. The fridge used to store specimens was dirty. We found multiple boxes stored in a cupboard containing sterile dresses. The cupboard was dirty and there was dirty stains and dust on top of the cardboard boxes. However, other ward areas were clean, well maintained and well furnished.

Clinic room and equipment

The clinic rooms was not checked for out of date items regularly. We found lots of out of date medical supplies in the clinic room. After the inspection the provider told us that all medical supplies had been checked and they had removed excess stock and clutter from the area. They informed us staff had been reminded to perform weekly medical supply checks and to dispose of out of date stock. However, clinic rooms were fully equipped with the right equipment suitable for children and young people, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

We found that the electrocardiogram (ECG) machine had not been calibrated since October 2021. After the inspection the provider told us they immediately removed the out of service ECG machine from the ward. They informed us the machine was not in use and it should have been removed to not cause confusion.

Safe staffing

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

Nursing staff

The service had high numbers of bank and agency support staff. During the 2 weeks prior to us visiting, the rate of agency staff use per shift ranged from between 0% and 71%. There were only 3 out of 24 shifts where no agency staff were used and agency use was below 11%. During this time staffing ranged from 6 to 12 staff per shift. This was an improvement since our previous inspection. However, the need for additional staffing above the wards core numbers was acknowledged due to the high acuity of children and young people on the ward at the time of our visit.

Managers used regular agency staff where possible but there were some occasions when they had to use staff that were new to the ward.

The service had enough nursing and support staff to keep children and young people safe. We reviewed this on the day of our inspection. Although the use of agency was high, the ward had no unfilled shifts. There were enough suitably qualified staff on each shift to carry out any physical interventions safely. We saw evidence that this was discussed in the morning flash meetings across the hospital. This was not discussed prior to our last inspection so this was an improvement.

The service had reducing vacancy rates. At the time of the inspection there were 3 health care assistant vacancies. There were also 5 health care assistants and 1 qualified nurse recruited and due to start with the service in the upcoming weeks. We were told the service had 7 new staff start within the previous 2 months.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, managers failed to ensure that agency induction checklists were fully complete.

Requires Improvement

Child and adolescent mental health wards

The service had low staff turnover rates. The average turnover for 2022 was 2.1%. the provider told us Mulberry ward had 28% of its staff leave over the last 12 months.

The average sick rate for 2022 was 5.3%. Managers supported staff who needed time off for ill health.

The ward manager could adjust staffing levels according to the needs of the children and young people. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. This varied based on the need of the children and young people on the ward at the time and we saw this vary as children and young people were discharged during our inspection visit.

Children and young people did not always have their 1 to 1 sessions with their named nurse recorded. Staff told us children and young people had 1 to 1 sessions with either their named nurse, second nurse or named healthcare assistant but we found no evidence of these in children and young people's care records.

Children and young people rarely had their escorted leave, or activities cancelled. However, 1 young person told us leave off the ward was limited. All children and young people had to have escorted leave regardless of their Mental Health Act status due to the ward being on the same site as adult wards for safeguarding purposes.

Staff shared key information to keep children and young people safe when handing over their care to others. We saw detailed handover documents. However, due to the ward not having a permanent administrator, handover paperwork was not always kept in the handover folder prior to it being filed, therefore not all staff could find it.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was always an available resident medical officer on site. The ward also had a specialist ward doctor and had access to a CAMHS consultant psychiatrist.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The service provided data across the whole hospital and did not break this down for child and adolescent mental health wards. The compliance rate for permanent staff across all mandatory courses was 88%. The compliance rate for bank staff was 71%. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

Staff did not always manage risks to children, young people and themselves well. Staff 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 children and young people's risk

We looked at 6 children and young people's electronic care records. Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. The ward manager had a system to check this when reviewing children and young people's incidents.

Requires Improvement

Child and adolescent mental health wards

Management of children and young people's risk

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk harm to themselves or others. We found that enhanced observations had not been carried out at the intervals prescribed. We randomly reviewed 4 young people's observation records for January 2023 and found that that the records had not been fully completed or recorded or exceeded the amount of observations that were required and patients had not been observed as frequently as they should have, leaving them unsafe. In addition, we found that 1 recording sheet for 1 young person was missing for a whole day. We were not assured that observations had been carried out to keep patients safe.

Not all staff had access to children and young people's electronic care records. Three staff told us not all agency staff could access patients' electronic care records. Agency staff did have access to paper care plans; however, we were told these were not always kept up to date.

Most staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, children and young people. Most staff we spoke with knew about the children and young people that they were working with and they were able to explain the key risk factors for each and they understood how to manage the risks for each young person. However, one staff member didn't know about 2 recent incidents which had occurred, and one staff member had not read children and young people's care plans.

Not all staff knew or understood the provider's policies and procedures on how to search children and young people or their bedrooms to keep them safe from harm. One staff member we spoke with did not know what to do. One young person told us staff were not managing prohibited items being brought onto the ward from leave and were not effectively searching other young people.

There was a blanket restriction in place. The dining room and kitchen were both locked for safety reasons at the time of our inspection but there was always a staff member in the communal area available to open these for children and young people if they required a drink. This restriction was monitored regularly and we saw evidence of this. Young people kept snacks in their bedrooms.

Managers across the hospital monitored and met to discuss patient risk regularly. Managers held daily flash meetings in which they discussed the handover from night to day staff, incidents, safeguarding matters, security issues, referral updates and staffing issues across the hospital. This meeting was attended by the leadership team, ward managers, medics, the maintenance team manager and housekeeping.

Use of restrictive interventions

Levels of restrictive interventions were high. Mulberry ward had a significantly higher number of incidents than any other ward in the hospital. this had reduced from 138 incidents in November 2022, to 86 in December 2022 and slightly increased to 99 in January 2023. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There was no seclusion room on the ward.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Requires Improvement

Child and adolescent mental health wards

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We found this when we reviewed children and young people's rapid tranquilisation records.

Safeguarding

Staff understood how to protect children and young people 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. The provider had a named nurse and doctor for child safeguarding and the hospital had a safeguarding lead.

Staff received training on how to recognise and report abuse.When we spoke to staff, theycould give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff had good links with external agencies.

Staff followed clear procedures to keep children visiting the ward safe. There was a family room off the ward where visits could be held so young children did not have to go onto the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a safeguarding lead and specialist social care staff to support staff where it was required.

Staff access to essential information

Staff had easy access to clinical information. Staff did not maintain or update paper records regularly.

Staff we spoke with told us not all staff could access children and young people's records easily.

The service used a combination of electronic and paper records. Paper records were not all up-to-date or complete. We reviewed 5 paper care records. Two of the 5 care records we looked at did not contain the child or young person's care plan, 2 records did not contain a record of the child or young person's capacity or consent to treatment and 1 record did not contain the child or young person's physical health checks. Two staff told us these were not kept up to date.

When children and young people transferred to a new team within the same provider, there were no delays in staff accessing their records using the electronic care recording system. During our inspection we witnessed a young person being admitted from another of the provider's services and staff had access straight away to their electronic care records.

Records were stored securely. All computers and laptops were password protected and all offices were locked.

Medicines management

Staff did not always provide specific advice to children, young people and carers about their medicines. However, the service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff did not always provide specific advice to children, young people and carers about their medicines. One young person told us their medication had changed without them being made aware first. One carer told us their relative was not consulted regarding their medicines and their requests were not listened to. Two carers told us they did not feel involved in their relative's medicines or preferred treatments. One carer told us there was poor communication with them on the changes to their relatives' medication. However, 1 young person told us they were aware of the medicines they receive and had no issues with them.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. External pharmacists regularly checked prescribing, recording, administration and storage of medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. These were discussed in team meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed children and young people's medicines regularly during multidisciplinary meetings.

Staff reviewed the effects of each child or young person's medication on their physical health according to National Institute for Health and Care Excellence guidance. However, 1 young person told us they felt the impact of medication on their physical health was not prioritised.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed children and young people's safety incidents well. 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 children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. During the 6 months leading up to this inspection there had been a high number of incidents reported. 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 children, young people and families a full explanation if and when things went wrong. It was clear from incident records that where incidents had occurred, parents were contacted at the earliest opportunity.

Managers debriefed and supported staff after any serious incident. All staff we spoke with told us they had debriefs after incidents. However, 1 staff member told us they felt they would benefit from debriefs after less serious incidents to discuss lessons learned.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. We saw evidence of this in records on the ward.

Requires Improvement

Child and adolescent mental health wards

Staff received feedback from investigation of incidents, both internal and external to the service. There was evidence that staff received feedback from investigation of incidents within team meeting minutes and other documents that staff would be able to access, such as newsletters. There was evidence that staff had access to regular reflective practice sessions.

Staff met to discuss the feedback and look at improvements to children and young people's care. We saw evidence of this in meeting minutes.

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 children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs. However, not all care plans were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. We saw evidence of this in all care records we reviewed.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We saw evidence of this or attempts to support children and young people with their physical health monitoring in all the care records we reviewed. However, 2 carers told us they were not satisfied with their relatives' physical health. One of these carers had been referred back to their GP for their relative's physical health concern.

Managers had not assured themselves that staff were following the providers guidance and taking appropriate action to escalate concerns where necessary if children and young people's paediatric early warning score (PEWS) records showed deterioration or that staff were scoring these correctly. Clinical records incorrectly showed that staff did not record or take action when children and young people's physical health deteriorated. We reviewed 10 children and young people's paediatric early warning score (PEWS) records. The clinical response to the paediatric early warning scores stated that if children and young people score 2-3, staff need to discuss the score with the duty doctor for possible review and determine the frequency of monitoring required, if 3 is scored in a single parameter then the young person requires an urgent duty doctor review. We found the staff had not followed this guidance. However, the provider told us after the inspection that they had reviewed all of the documents and all the children and young people's observations were within normal range but they had identified that the documentation had been incorrectly scored.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. Staff regularly reviewed and updated care plans when children and young people's needs changed. We saw evidence of this in all care records we reviewed.

Requires Improvement

Child and adolescent mental health wards

Not all care plans were personalised, holistic and recovery-orientated. We reviewed 6 children and young people's care plans, 1 care plan appeared generic and not patient centred. However, we saw in another young person's records they had declined to take part in the care planning process and staff had documented this.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people 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. They also participated in clinical and ward audits.

Staff provided a range of care and treatment suitable for the children and young people in the service. Children and young people had access to an art therapist on both an individual and group basis, and yoga. Children and young people also had access to psychological interventions recommended by the National Institute for Health and Care Excellence. This included individual and group support such as cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT).

Staff identified children and young people's physical health needs and recorded them in their care plans. However, staff could not find the physical health care plan for 1 young person at the time of our inspection. The service provided evidence of this after the inspection.

Staff made sure children and young people had access to physical health care, including specialists as required. There was always a doctor available if required.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Staff encouraged children and young people to eat healthier snacks and there was a regular delivery of fruit to the ward.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. For example, staff used the Children's Global Assessment Scale (CGAS) to assess the overall level of functioning and impairment. The ward used Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) to assess and record children and young people's treatment outcomes.

Staff took part in clinical and ward audits and managers used results from audits to make improvements. Audits included those of ligature and environmental risks, hand washing, the restricted cupboard, personal emergency evacuation plans clinic room and safety audits. However, we found the clinic room audit was not sufficient to identify out of date medical supplies.

Skilled staff to deliver care

Managers did not always provide opportunities for staff to update and further develop their skills. However, the ward team included or had access to the full range of specialists required to meet the needs of children and young people on the ward. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward. The multidisciplinary team included doctors, psychologist, art therapist, teachers, managers, nurses, healthcare assistants and a ward administrator on a part time basis.

The service had an online training platform but not all staff had accessed to training to meet the needs of children and young people they were supporting. Out of the six staff we spoke with, one staff member told us they had not had child and adolescent mental health services related training. Two staff members told us they had not had diabetes awareness training even though there was a young person on the ward with type 1 diabetes. However, staff were aware of diabetes management and were managing this safely.

Managers ensured most staff had the qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Managers kept a record of the training compliance of all staff.

Managers gave each new member of staff a full induction to the service before they started work. Managers supported staff through regular, constructive clinical supervision and annual appraisals of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed minutes of these from 14 September 2022 to 11 January 2023 and saw staff attended regularly. Minutes were available for staff to refer back to. However, staff we spoke with were unable to find the meeting minutes for December 2022 but assured us the meeting had taken place.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward team 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 children and young people and improve their care. Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We saw evidence of this in meeting minutes and handover records.

The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. For example, staff worked closely with individual GP's, community mental health teams, voluntary organisations and commissioners.

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 children and young people's 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 guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service had a Mental Health Act office on site. The provider also had a head of Mental Health Act and Mental Capacity Act operations lead who was available if required.

Requires Improvement

Child and adolescent mental health wards

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. Staff were aware of these and how to access them.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. Staff displayed posters on the ward relating to advocacy services and independent mental health advocacy services. Children and young people knew they could speak to an advocate and how to contact them and they visited the ward regularly.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. We saw evidence of this in children and young people's care records.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Two young people told us they had grounds leave. However, 1 young person and 1 carer told us leave off the ward was limited.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. We saw copies of these in children and young people's paper care records in the ward office.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and staff we spoke with had a good understanding of at least the five principles. Staff we spoke with understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. Staff also knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

There was a clear policy on Mental Capacity Act, which staff we spoke with could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Staff made a record of children and young peoples' mental capacity to consent to treatment, in all electronic care records we reviewed.

Requires Improvement

Child and adolescent mental health wards

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Not all staff treated children and young people with compassion and kindness or respect their privacy. Not all staff understood the individual needs of children and young people or supported them to understand and manage their care, treatment or condition.

Not all children and young people felt safe on the ward. Two young people told us they did not feel safe on the ward due to the ward being unsettled and 1 young person told us they felt unsettled on the ward.

Most staff were discreet, respectful, and responsive when caring for children and young people. However, 2 young people told us staff do not carry out their enhanced observations properly and one young person told us that despite them being on enhanced observations they were able to self-harm. Two young people told us staff bring in and use restricted items on the ward such as their mobile phones. One young person told us they did not have a lot of privacy.

Most staff followed policy to keep children and young peoples' information confidential. However, we observed staff coming into a busy office to give feedback on a meeting they'd had with a young person while staff were on the phone to a young person's relative.

Not all children and young people said staff treated them well and behaved kindly. One young person told us a number of staff are not caring and rude. However, most staff gave children and young people help, emotional support and advice when they needed it. One young person told us regular staff were caring and understanding and another young person told us some staff were good.

Not all staff understood and respected the individual needs of children and young people. One young person said temporary staff did not understand their needs, engage with them and were not respectful or show empathy.

Involvement in care

Staff did not always involve children, young people and their families in care planning and risk assessment. However, staff ensured that children and young people had easy access to independent advocates.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. We saw detailed admission packs which children and young people were given on admission to the ward. This gave information about the ward and the young person's care and treatment such as the staff team, different therapies, education and their rights.

Requires Improvement

Child and adolescent mental health wards

Staff did not always involve children and young people or give them access to their care planning and risk assessments. One care plan we reviewed appeared generic and not patient centred. One young person told us they have a care plan, but they have not received a copy of it. Two young people told us they were given a copy of their care plan but it was inaccurate, so it had to be changed.

Staff made sure children and young people understood their care and treatment. Children and young people had weekly meetings to discuss this.

Staff involved children and young people in decisions about the service, when appropriate. We saw children and young people's involvement in the decoration of the ward. We were shown areas of the ward where young people had painted murals on the walls and written personalised messages or put hand prints.

Staff supported children and young people to make decisions on their care. We saw evidence of this being discussed in weekly multidisciplinary meetings involving children and young people. Children and young people could give feedback on the service and their treatment and staff supported them to do this. Children and young people had regular community meetings where they could feedback on the ward and their care and treatment.

Staff made sure children and young people could access advocacy services. Advocacy visited the ward weekly and we saw information posters displayed on the ward. One young person said the advocacy service had improved with the advocate visiting the ward more regularly.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff did not always inform and involve families or carers. We spoke to 3 children and young peoples' carers. Two carers told us they were not involved in their relatives' care or treatment. Both carers told us they did not feel involved or updated regarding their relative's medicines. One carer told us they were not involved in their relative's care planning or meetings until recently.

Staff gave carers information on how to find the carer's assessment. Information about accessing a carers assessment was given to all carers in the welcome pack given to them when their relative was admitted to the ward.

Is the service responsive?

Good

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

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. Between 1 November 2022 and 31 January 2023, the average length of stay for Mulberry ward was 71 days.

The service had low out-of-area placements. Managers told us they had 1 out of area placement in the last 3 months.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. We saw a clear admission pathway including an assessment pathway, stabilisation pathway and discharge pathway based on the child or young person's length of stay. Discharge was discussed with children and young people in multidisciplinary meetings.

When children and young people went on leave there was always a bed available when they returned.

Children and young people were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interest. We saw, and were told, children and young people were moved between the provider's hospitals when it was in their best interests, for example if they needed more or less support.

Staff did not move or discharge children and young people at night or very early in the morning.

Staff told us they had to wait for a bed to become available to transfer young people to if required. There is a shortage of psychiatric intensive care unit beds available across the country. There was not always a bed available if a child or young person needed more intensive care and they may have to wait for a bed to become available. This was not always close to the child or young person's family and friends. Staff were mitigating this risk by using enhanced observations whilst waiting for a psychiatric intensive care bed.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed and took action to reduce them. The provider told us there was 1 young person whose discharge was delayed. Most children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. We saw that discharge was discussed with children and young people in multidisciplinary meetings. However, 2 young people told us they had no plans for discharge despite being on the ward for a substantial period of time and 1 young person told us that despite turning 18 in a few weeks they had no transition plan and they were concerned what will happen to them.

Staff supported children and young people when they were referred or transferred between services. For example, if they required treatment in an acute hospital or transferred to another of the provider's hospitals. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. Children and young people could make hot drinks and snacks at any time. However, there were limited quiet areas for privacy. Not all children and young people were happy with the food available on the ward.

Requires Improvement

Child and adolescent mental health wards

Each child and young person had their own bedroom, which they could personalise. We viewed children and young people's bedrooms and they had customised them with pictures and belongings to their own preferences. Each child and young people had a secure place to store personal possessions on the ward.

Staff used a range of rooms and equipment to support treatment and care. There was a large communal corridor with seating for children and young people to socialise, a lounge, dining room, small therapy / meeting room and a classroom on the ward children and young people could access for education. However, there was limited additional space to allow children and young people to de-escalate or have a quiet space other than their bedrooms.

The service had a room where children and young people could meet with visitors in private. Children and young people could access a separate visitors' room off the ward so visitors could bring children and keep them safe and away from the ward environment.

Children and young people could make phone calls in private. All children and young people had access to mobile phones.

The service had an outside space that children and young people could access easily. There was a garden linked to the ward which children and young people could access with staff supervision.

Children and young people could access snacks at any time and were not dependent on staff. Children and young people were able to keep snacks in their bedrooms.

Not all children and young people were happy with the food available on the ward. One young person told us the food was not good, there was a lack of variety and it was poor quality. Another young person told us the food provided was not nice.

Children and young people's engagement with the wider community

Children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and supported them. Children and young people had access to an educational facility onsite during the week. We saw teachers trying to engage with children and young people who initially did not want to engage in education activities. We saw Education, Health and Care Plans for children and young people who required them. Two young people and 1 carer told us the education provision was good.

Staff helped children and young people to stay in contact with families and carers. Staff facilitated regular family and carer visits on the ward.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication and advocacy support.

Requires Improvement

Child and adolescent mental health wards

The service met children and young peoples' specific communication needs on an individual basis. Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. Managers made sure staff, children and young people could get help from interpreters or signers when needed. The service had information leaflets available in languages spoken by children, young people and the local community. The information provided was in an age appropriate format.

The ward was on the first floor and did not have disabled access and could not support disabled people.

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.

Most children, young people, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in communal areas. There was information about how to complain on an information board displayed on the ward. One young person told us they didn't know how to make a complaint, but they were aware of the information on the ward if they needed it. One carer told us they had raised a formal complaint and met with hospital managers.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew what to do if a young person raised a complaint. They protected children and young people who raised concerns or complaints from discrimination and harassment. However, 1 young person told us nothing gets done with issues and complaints leaving young people frustrated. Another young person told us they had tried to make a complaint, but staff did not listen and they felt staff could be dismissive.

Managers investigated complaints and shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of this being shared in the morning flash meeting, governance meeting and team meeting minutes.

The service used compliments to learn, celebrate success and improve the quality of care. We saw lots of cards and compliments displayed in the staff and managers office as well as messages from children and young people who had previously been discharged from the ward as part of the ward decoration.

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 children, young people, families and staff.

Requires Improvement

Child and adolescent mental health wards

Leaders had a good understanding of the needs of the children and young people and how to address these. Leaders had a comprehensive understanding of the service they managed. Leaders could explain clearly how the teams were working to provide high quality care.

Staff told us leaders were supportive and approachable. Staff felt listened to and supported to develop their skills and knowledge further. Staff knew who the local leaders were.

Vision and strategy

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

During the inspection we observed staff displaying the providers values in their interactions with children and young people and colleagues. However, some young people told us staff did not always interact with them appropriately.

Staff we spoke with were able to describe the values and how these formed the basis of their work.

The hospital director and ward managers held regular meetings to discuss performance, staffing issues and risk. The learning and information from these meetings was cascaded up and down to other regional, hospital and ward based meetings.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff said they felt leaders and their colleagues were supportive and felt respected and valued in their teams.

Staff knew how to use the whistle-blowing process if they needed to. Staff at all levels were actively encouraged to speak up and raise concerns. Staff consistently stated they felt able to raise concerns without fear. Staff described an open and supportive culture.

Leaders dealt with poor staff performance when needed. Leaders dealt with areas of concern including behaviours and attitudes of staff.

Governance

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

Managers had not ensured staff followed the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk harm to themselves or others.

Managers had not ensured all staff had access to children and young people's electronic care records.

Requires Improvement

Child and adolescent mental health wards

Managers failed to ensure that agency induction checklists were fully complete. We found on 23 January 2023 for 3 agency staff members, their induction checklists and observation competency checklists had been completed and signed in multiple places by the agency staff member but not the permanent staff member / inductors name or signature. On 24 January 2023 for 1 agency staff member their induction checklist had been completed but not signed by the agency staff member. Due to the checklists not being completed correctly we were not assured that staff had been fully inducted. Although, we confirmed with 1 agency staff member they had been inducted to the ward.

here were insufficient or ineffective systems and processes to ensure that medical equipment and devices stored in the clinic room were kept in date, calibrated and cleaned regularly. We found out of date medical supplies during the inspection which staff disposed of at the time they were found. The provider told us after the inspection that all medical supplies had been checked and they had removed excess stock and clutter from the area. Staff had been reminded to perform weekly medical supply checks and to dispose of out of date stock.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at a ward and senior management team level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Management of risk, issues and performance

Most staff had access to the information they needed to provide safe and effective care and used that information to good effect.

The service had systems and processes in place to monitor risk and performance. The service held daily morning flash meetings to review incidents, safeguarding matters, security issues, referral updates and staffing issues across the hospital. The service also held handover meetings to discuss incidents, children and young peoples' risks, and any issues of concern. Managers formed plans and actions to address these.

The ward had access to the service risk register in place which they used to record, review and manage risks to the ward.

Information management

Staff engaged actively in local and national quality improvement activities.

Staff told us they had access to the equipment and information technology needed to do their work.

The team took part in regular audits on practices on the ward including adherence to Mental Health Act and Mental Capacity Act legislation, restrictive practice, risk assessment and care plan audits, ligature audits, health and safety audits and garden audits.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Requires Improvement

Child and adolescent mental health wards

There were high levels of constructive engagement with staff and children and young people. The ward used several methods to communicate with staff and children and young people that included its own website, bulletins, emails, displays, intranet and children and young peoples' community meetings.

Learning, continuous improvement and innovation

The ward participated in and were working towards the Quality Network for Inpatient CAMHS (QNIC). However currently the award requires disabled access to be direct to a ward environment. The disabled access that allowed people to get to the first floor did not open directly on to the ward. We were told the criteria for disabled access, to meet this award was changing in the future.

Good

Substance misuse services

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

Is the service safe?

Good

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

Safe and clean care environments

All clinical premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the facility layout

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

Staff could observe clients in all areas of the service. The service had installed closed circuit television (CCTV) in all communal areas of the ward. Staff could observe images from the CCTV on a large screen in the nurses' office.

The service managed risk and client safety where there was mixed sex accommodation. All bedrooms had full ensuite facilities. There was a comfortable, well-furnished lounge for the use of female clients only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep clients safe. All patient bedrooms had anti-ligature fittings such as collapsible curtain rails and anti-ligature door fittings. Ensuite wet rooms were fitted with anti-ligature doors.

Staff had easy access to alarms and clients had easy access to call systems. Personal alarms were available for all staff. There were call buttons in clients' bedrooms.

Maintenance, cleanliness and infection control

Good

Substance misuse services

All areas were clean, well maintained, well-furnished and fit for purpose. All areas of the ward were clean and well maintained. The ward was decorated to a high standard with attractive colour schemes, furniture, lighting, mirrors and carpets.

Staff made sure cleaning records were up-to-date and the premises were clean. The service employed housekeepers to ensure the ward was always clean and tidy.

Staff followed infection control policy, including handwashing. The service completed infection prevention and control compliance audits. The results of these audits were reviewed by the divisional clinical governance group.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room was clean and well organised. There was a couch in the clinic room, along with equipment to monitor clients' physical health. A bag containing equipment for use in an emergency was stored in the clinic room. Emergency drugs were stored in a sealed box and checked by the pharmacist. However, the door to the clinic room was not self-locking.

Staff checked, maintained, and cleaned equipment. Staff checked the emergency bag each week. Staff checked the defibrillator each day. Records of fridge temperatures used to store client's medicines were up to date and in order.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep clients safe. The ward employed 5 registered nurses and 6 healthcare assistants. Three staff worked on each shift. During the day there were 2 registered nurses and 1 healthcare assistant assigned to the ward. At night, there was one registered nurse and 2 healthcare assistants. All staff and clients said they felt safe on the ward.

The service had low vacancy rates. There was one vacancy for a registered nurse and one vacancy for a healthcare assistant. A registered nurse had been appointed to the vacant post and was due to start in the week after the inspection.

The service had low rates of bank and agency nurses. The service occasionally used agency staff to cover shifts in the event of unexpected absences by permanent staff, such as absence due to sickness. Most agency staff were employed on long-term contracts. For example, one agency nurse had been working on the ward since 2020. Both staff and clients said they valued the consistency of staffing.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Agency staff completed an induction checklist and a competency check relating to observations of clients.

Managers supported staff who needed time off for ill health. Staff said that the occupational health department provided additional support for staff who needed time off for sickness.

Clients had regular one-to-one sessions with their named nurse. Nurses said there was plenty of time for them to have individual sessions with clients and that this was a routine part of their work.

Clients rarely had their escorted leave or activities cancelled. There were sufficient staff to facilitate leave and activities. Escorted leave was always facilitated.

Staff shared key information to keep clients safe when handing over their care to others. Staff held handover meetings at the start of each shift. At these meetings, they shared key information on clients' presentation and risks.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward admitted clients from five visiting consultants who had practising privileges at the hospital. The specialty doctor was based on the ward who provided discharge summaries and liaised with visiting consultants. An on-call doctor was available across the hospital site outside of office hours. Visiting consultants participated in the on-call rota.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff on Manor Ward had completed 97% of mandatory training.

The mandatory training programme was comprehensive and met the needs of clients and staff. This covered intermediate life support, infection control, health and safety, reducing restrictive interventions and safeguarding.

Assessing and managing risk to clients and staff

Staff screened clients before admission and only admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. However, staff did not always complete physical health checks of clients withdrawing from alcohol dependency at the frequency set out in the doctor's instructions.

Assessment of client risk

Staff completed risk assessments for each client on admission, using a recognised tool, and reviewed this regularly, including after any incident. All clients' admissions were arranged by their consultant psychiatrist. The consultant included details of any immediate risks in their record authorising the admission. Staff completed a formal risk assessment when the client arrived on the ward. Staff updated risk assessments each week and after any risk incidents. Staff completed a risk assessment each time a client left the ward on leave. This included a brief assessment of the client's mental state, details of any incidents in the previous 24 hours, a description of the clothes they were wearing, a contact telephone number and a record of the time they were due to return.

Staff used a recognised risk assessment tool. Risks assessments were completed using a standard form on the electronic client record.

Management of client risk

Staff knew about any risks to each client and acted to prevent or reduce risks. The primary risks for clients were associated with relapse or withdrawal symptoms. When clients were admitted to the ward, they were placed on intermittent observations. This involved staff checking on them 4 times every hour. On rare occasions when a client was identified as at risk of using a ligature, staff withheld items that could present a risk such as belts, shoelaces, electric cables and razors. In these circumstances, staff withheld these items with the agreement of the client and their consultant. Staff held a handover meeting at the start of each shift to review the risks for each client.

For clients completing a medically assisted withdrawal from alcohol, staff completed a structured assessment of their withdrawal symptoms. However, the records for all three patients showed that whilst the admitting consultant asked for these assessments to be completed 4 times a day, they were only completed between one and three times per day. When the patient's withdrawal symptoms had reduced, nurses made decisions about changing the frequency of these assessments without discussions with the consultants or multidisciplinary team. We raised this with the ward manager during the inspection. They provided an assurance that staff would be reminded of the process for adjusting the frequency of assessment and their compliance with this process will be monitored.

Staff identified and responded to any changes in risks to, or posed by, clients. Staff reviewed clients at daily handover meetings and at least once a week with the visiting consultant. Staff responded to changes in risk. For example, once clients had become settled on the ward and the risk reduced, they were able to have leave from the ward.

Staff followed policies and procedures when they needed to search clients or their bedrooms to keep them safe from harm. All clients were motivated to participate in the treatment programme. Any searches were carried out with the consent of clients. If staff suspected that a client had bought prohibited items onto the ward, and the client refused a search, the matter would be discussed with the client's consultant. The consultant would then talk to the client about the concern and consider whether it was the right time for them to participate in the programme.

Use of restrictive interventions

Levels of restrictive interventions were very low. The service did not use restrictive interventions, such as restraint. Any restrictions placed on clients would be carried out with the client's agreement. For example, a client may request, or agree to staff withholding their mobile phone to remove their temptation to contact people associated with their former drug use.

Safeguarding

Staff understood how to protect clients 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. Staff displayed information in the nurses' office about how to identify and report abuse. Staff gave examples of situations when they had raised safeguarding concerns such as when they became aware of domestic violence or risks to children.

Staff kept up to date with their safeguarding training. Ninety-seven percent of staff at the hospital had completed mandatory training on safeguarding.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. For example, when clients had disclosed information about abuse in therapy sessions, staff escalated this to the safeguarding lead.

Staff followed clear procedures to keep children visiting the ward safe. All visits from children were agreed with the consultant and ward manager.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. In the first instance, staff reported any concerns to the safeguarding lead for the hospital. They also recorded their concerns on the electronic incident record. A weekly safeguarding meeting was held at the hospital, attended by the safeguarding leads and director of clinical services. Information from these meetings was sent to ward managers who shared this with staff at team meetings.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Client notes were comprehensive, and all staff could access them easily. Each client had an electronic record including assessments, results of physical health observations and daily progress notes. Nurses, healthcare assistants, doctors and therapists updated records on the daily progress notes. Daily progress referred to relevant parts of the care plan.

Records were stored securely. Staff could only access the record system by entering a personal username and a password.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service used an external pharmacy service to order medicines. Staff said the process for this was very easy, using an online system. Staff used an electronic medicines management system to ensure that medicines were administered and managed safely. The external pharmacy also completed regular checks and audits of medicines management and medicines administration records.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Doctors met with clients at least once a week to review prescribed medicines.

Staff completed medicines records accurately and kept them up to date. Medicines records were completed on the electronic system. All these records were up to date.

Staff stored and managed all medicines and prescribing documents safely. All medicines were stored in the clinic room. Controlled drugs were usually checked at the start and end of each shift. However, there were two gaps in the records for checks on controlled drugs during the week before the inspection. We raised this matter with the ward manager. They provided an assurance that staff would be reminded of the importance of records relating to controlled drugs and their compliance with the process for recording checks will be monitored. Staff kept the door to clinic room locked when they were not using the room, although the door was not self-locking.

Good

Substance misuse services

Staff followed national practice to check clients had the correct medicines when they were admitted, or when they moved between services. All clients were seen by a doctor when they were admitted. The doctor reconciled their existing medicines and prescribed on the electronic prescribing system.

Staff reviewed the effects of each client's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. For example, staff completed assessments of alcohol withdrawal to identify whether medicines were helping to moderate client's symptoms.

Track record on safety

The service had a good track record on safety. Staff had reported 8 incidents between October and December 2022. This number of incidents is low.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff had reported 8 incidents between October and December 2022. Managers discussed all incidents at monthly clinical governance meetings. Staff used debriefing folders to record and communicate learning after incidents. This included a record of what had gone well and where there were areas for improvement.

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 completed comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each client either on admission or soon after. Each client's consultant completed a full assessment of them on admission, including an assessment of their mental health.

All clients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. When clients were admitted, doctors carried out a full assessment of their health including vital signs, blood tests, a urinary drug screen and electrocardiogram. If tests showed that clients had any physical health conditions, staff monitored these throughout their admission. For example, staff created an alert on the client's electronic record if they had type I diabetes.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. Each client had four care plans relating to keeping safe, keeping well, staying connected and staying healthy. Care plans were relevant and informative.

Staff regularly reviewed and updated care plans when clients' needs changed. Each client met with their key worker each week to review their progress. Care plans were updated to reflect these discussions.

Care plans were personalised, holistic and recovery-orientated. Care plans were specific to the individual needs of clients. For example, one of the care plans provided details of how the client would receive tailored support for their mental health alongside their involvement in the addiction treatment programme. These plans were developed collaboratively and written in the client's own words.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients 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 clients in the service. The service offered two addictions treatment programmes; a 7-day programme and a 28-day programme. The 7-day programme included a medically assisted withdrawal from drugs or alcohol alongside a therapeutic programme that focused on rest and recovery. For example, therapeutic work on the 7-day programme typically included art therapy, yoga, fitness, mindfulness, relaxation, walks and engaging in films and podcasts about sustainable recovery.

The 28-day programme also included medically assisted withdrawal along with a more comprehensive therapeutic programme based on steps 1 to 3 of the 12-step recovery programme. The 12-step programme is a widely used and recognised psycho-social programme for people with addictions. Clients were engaged in therapeutic work for at least five hours each day. The therapy timetable included sessions on dialectical behavioural therapy, transactional analysis and addictions groups. Most work took place in groups, along with at least one individual session with a therapist each week. Psychotherapeutic groups provided the opportunity for clients to share their experiences in a supportive environment. Doctors provided medically assisted withdrawal from drugs and alcohol. Doctors acknowledged that some clients with addictions also had underlying mental illness, such as depression or psychosis, which they treated alongside the addictions treatment programme. Doctors prescribed vitamins, including injectable vitamins, to clients receiving detoxification from alcohol in order to prevent memory loss.

Staff delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence. For example, doctors prescribed chlordiazepoxide to clients withdrawing from alcohol, titrating the dose downwards over 7 to 10 days.

Staff identified clients' physical health needs and recorded them in their care plans. Each client had a 'staying healthy' care plan that gave details of how any physical health needs were being met.

Staff made sure clients had access to physical health care, including specialists as required. For example, the speciality doctor for the ward had been liaising with a cardiologist regarding a client with high blood pressure.

Staff helped clients live healthier lives by supporting them to take part in programmes or giving advice. During the first week of the programme, staff focused on enabling clients to rest and recover. Staff encouraged clients to eat well, take exercise and focus on their well-being. Smoking was prohibited.

Staff used recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. Therapy staff used the psychological health questionnaire and the generalised anxiety disorder questionnaire to measure the severity of clients' conditions. However, whilst the admitting consultant noted an estimate of the client's alcohol consumption on their admission record, the service did not use any structured questionnaires to measure the severity of alcohol dependence.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had 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 a full range of specialists to meet the needs of the clients on the ward. The ward employed a ward manager, deputy ward manager, healthcare assistants and a ward doctor. The therapies team included specialists in addictions therapy, art therapy, psychotherapy, cognitive behavioural therapy and dialectical behavioural therapy. The clients' consultant psychiatrists worked on a visiting consultant basis and regularly attended the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff. Registered nurses had completed a test of their competencies relating to the addictions treatment programme. Therapy staff had either achieved or were working towards accreditation by the British Association for Counselling and Psychotherapy. Staff displayed information about withdrawal symptoms and symptoms of degenerative brain disorder that can result from alcohol abuse in the nurses' office to raise awareness among all staff.

Managers gave each new member of staff a full induction to the service before they started work. Newly appointed permanent staff participated in a two-week induction programme. During this period, staff completed mandatory training, read policies and procedures and worked alongside experienced staff to gain an understanding of the ward. As part of this induction, staff were required to read the local policy on medically assisted withdrawal from drugs and alcohol.

Managers supported staff through regular, constructive appraisals of their work. Managers completed a performance and development review each year. A review was carried out with new staff during their probationary period.

Managers supported staff through regular, constructive clinical supervision of their work. The supervision record for December 2022 showed that ward staff had received a combination of managerial supervision, clinical supervision and team supervision. Managerial supervisions were held by with ward manager and involved discussions about the member of staff's development, aspirations, performance and training. In clinical supervision, staff discuss clinical matters, complex clients and incidents.

Managers made sure staff attended regular team meetings or gave information from those who could not attend. Ward staff held a team meeting once a month. During these meetings, staff discussed feedback from the hospital's senior management team, staff morale, training sessions and feedback from quality reviews.

Good

Substance misuse services

Managers made sure staff received any specialist training for their role. The service provided training on the addictions treatment programme for all its staff. Nurses, healthcare assistants and therapy staff had completed training in medically assisted withdrawal. A consultant psychiatrist had presented a training session on alcohol dependency. Members of the therapy staff had provided training to nurses and healthcare assistants on the 12-step recovery programme and cycles of development. A therapist had applied for training in eye movement desensitisation response.

Multi-disciplinary and interagency team work

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

Staff made sure they shared clear information about clients and any changes in their care, including during handover meetings. Staff held handover meetings at the start of each shift. Notes of the handover meetings included the entry made onto each clients' record during the previous shift. Paper copies of the handover notes were kept in a file in the nursing office for 7 days.

Ward teams had effective working relationships with external teams and organisations. Consultants contacted clients' general practitioners (GPs) when clients were admitted and discharged from the ward. They also spoke to GPs if clients had specific physical health conditions.

Good practice in applying the Mental Capacity Act

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

The admitting consultant recorded details of the clients' mental capacity on the admission record to confirm that the client was agreeing to the admission and willing to engage in the programme of treatment. Details of clients consent to treatment was stored in a specific client information folder.

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

Staff were discreet, respectful, and responsive when caring for clients. There was a calm and relaxed atmosphere on the ward. We observed good interactions between staff and clients throughout the inspection.

Good

Substance misuse services

Staff gave clients help, emotional support and advice when they needed it. Staff said they developed empathic, person centred, therapeutic relationships with clients. They were proud of the strength of these relationships. Nurses said they enjoyed spending time with clients.

Staff supported clients to understand and manage their own care treatment or condition. Clients said they had received comprehensive physical health checks and discussed the results of these with staff. Clients had a one-to-one meeting with a therapist at least once a week to reflect upon and discuss their progress. Visiting consultants also met with their clients at least once a week.

Staff directed clients to other services and supported them to access those services if they needed help. For example, staff encouraged clients to access alcohol recovery groups in the community and leave to enable clients to attend these groups.

Clients said staff treated them well and behaved kindly. Clients gave very positive feedback about the staff. They said staff were very supportive and keen to help them. Clients felt confident that they could approach members of staff at any for time help and support.

Involvement in care

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

Involvement of clients

Staff introduced clients to the ward and the services as part of their admission. A healthcare assistant provided clients with an orientation to the ward. Clients also received an admission pack. This pack included information for clients on risk assessments, arrangements for leave, consent to share information, observations and the conditions of their admission. The packs also contained information about prohibited items, potential restrictions on mobile phone use and clients' legal rights.

Staff involved clients and gave them access to their care planning and risk assessments. Clients said they had been involved in care planning and had copies of their care plans. Records of multidisciplinary team meetings showed that clients were involved in discussions about leave and setting goals for their treatment.

Clients could give feedback on the service and their treatment, and staff supported them to do this. The ward held a community meeting for clients once a week. During these meetings, clients talked about mutual expectations, how everyone was getting on with each other, the ward environment, food and catering, achievements and overall feedback. Staff displayed positive feedback in cards and letters on a notice board by the nurses' office. Staff told us about positive feedback from clients who had said they had felt nurtured and listened to.

Staff made sure clients could access advocacy services. Contact details for the clients' advocacy service were displayed on a notice board.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Good

Substance misuse services

Staff supported, informed and involved families or carers. Staff supported clients to maintain contact with their family when clients wanted this. Families visited clients on the ward. A therapist provided a support group one evening each week for clients' friends and families. On some occasions, a therapist met with the client and their family to plan the client's discharge. Doctors asked clients for permission to contact their families. When clients gave permission, families were invited to ward rounds. When family members were unable to attend ward rounds the doctor telephoned them after the meeting to provide feedback.

Is the service responsive?

Good

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

Access and discharge

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

Bed management

The service admitted clients whose primary concern was addiction. The ward only admitted clients who were motivated and ready to engage in the therapeutic programme. The ward offered two specific treatment programmes. One programme was for 7 days. The other was for 28 days. Clients could stay beyond 28 days if they wished to, but this would be in order to achieve specific goals agreed with the therapy team. The ward admitted clients with a dual diagnosis of addiction and mental illness if the mental illness was a secondary diagnosis. Clients with a primary diagnosis of mental illness were referred to another hospital nearby. Clients presenting a high risk of harm to themselves or other people were referred to the National Health Service.

Managers did not make sure that bed occupancy did not go above 85%. If appropriate referrals were made to the service, they would operate at 100%.

Discharge and transfers of care

Staff carefully planned clients' discharge. When clients completed the 7- or 28-day programme, they were able to attend a weekly aftercare group to continue work on the recovery programme. Clients were seen for outpatient appointments at the nearby well-being centre. Staff also encouraged clients to participate in drug and alcohol recovery groups in the community.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

Each client had their own bedroom. All bedrooms were well-furnished with ensuite facilities and decorated to a good standard.

Good

Substance misuse services

Clients had a secure place to store personal possessions. All clients had a lockable cupboard in their bedroom. Clients could store restricted items in the nurses' office.

The service had a full range of rooms and equipment to support treatment and care. Staff and clients could access these rooms. The ward had rooms for individual and group therapies. There was a clinic room with an examination couch and offices for staff.

The service had quiet areas and a room where clients could meet with visitors in private. Most clients met with visitors in the dining room or the garden. Clients often met with visitors off the ward.

Clients could make phone calls in private. Clients had access to their own mobile telephones. Clients could use a cordless telephone in the nurses' office if they needed to.

The service had an outside space that clients could access easily. The ward had a large well-maintained garden that could be accessed through the dining room. Staff completed a risk assessment of clients before allowing them access to the garden.

Clients could make their own hot drinks and snacks and were not dependent on staff. There was a communal kitchen where clients could make snacks, teas, coffee and hot chocolate.

The service offered a variety of good quality food. The service provided a menu of good quality, healthy food.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication needs.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were two bedrooms on the ground floor that had been adapted to meet the needs of disabled clients. Staff assessed clients and adapted the therapeutic programme to respond to their individual needs. When the service admitted transgender clients, staff used their preferred pronouns.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. The ward displayed accessible information on physical health, treatment programmes, local services, advocacy services and guidance on how to complain about the service.

The service provided a variety of food to meet the dietary and cultural needs of individual clients. Meals could be prepared to meet the individual needs of all clients.

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.

Clients, relatives and carers knew how to complain or raise concerns. When clients arrived on the ward, staff provided them with a welcome pack. This included information about the service, including details of how to make a complaint.

Good

Substance misuse services

The service clearly displayed information about how to raise a concern in client areas.

Managers investigated complaints and identified themes. Complaints were reviewed at monthly clinical governance meetings. This included a review of compliant with response times for complaints and discussion about the themes that had arisen.

Is the service well-led?

Good

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

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 clients and staff.

The ward manager was a registered nurse. They had worked at the hospital for over 10 years. They were managed by the director of clinical services. Managers were visible on the ward and attended handover meetings. Some of the senior staff had begun working at the hospital as healthcare assistants and became managers after working in different roles across the hospital.

Vision and strategy

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

The strategy for the service involved increasing the provision of training for staff and ensuring a good level of staff retention. Staff could access information about the Priory Group through the organisation's intranet and regular communication from senior managers.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff said they liked working at the hospital. They felt valued and supported. They described the senior management team as being present and approachable. They also said staff worked well together in their immediate teams. Senior managers had held events to encourage staff to feel valued including a pizza night for night staff. Staff said they were motivated by seeing clients get better and said they found the work rewarding.

Staff said that if they had any concerns about the ward they would feel confident in raising these with the ward manager.

Governance

Good

Substance misuse services

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers held clinical governance meetings for the hospital once a month. At each meeting, staff reviewed information about the hospital, following a set agenda. This included a review of the patient and carer experience, adverse events, clinical effectiveness and continuous improvement. The last meeting included a presentation by the pharmacist of their three-month review of medicines management. Ward managers gave staff feedback from clinical governance meetings. However, the clinical governance process had not identified that physical health checks for patients withdrawing from alcohol were not being completed at the frequency required by the consultant.

The medical director attended clinical governance meetings to represent the interests of doctors. Visiting consultants attended a quarterly medical advisory committee.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The hospital maintained a risk register for the whole site. The service had introduced some contingency arrangements. For example, paper records for handover meetings, including all entries from the clients' record for the previous day, were kept for 7 days. This meant that recent information about clients would still be available if there were difficulties in accessing the electronic client records.

Information management

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

Information was collated on the electronic client record. Data about the overall performance of the hospital was reviewed at clinical governance meetings.

Learning, continuous improvement and innovation

Staff showed a general desire to improve the services they provided to their patients. However, there were no specific improvement programmes or quality improvement initiatives taking place at the time of our inspection.

Requires Improvement

Specialist eating disorder services

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed thorough risk assessments of all wards areas, and removed or reduced any risks they identified, but did not always review risk assessments in a timely manner. We reviewed environmental risk assessments for the ward and found these were comprehensive but found that staff had not updated the garden risk assessment following an incident. Service protocol indicated this should be updated after any incident of absconsion in the garden area. A patient had absconded from the garden by climbing over the fence on 5 November 2022 and had made two further attempts in the days following the incident, but the garden risk assessment had not been updated since 23 October 2022.

However, we reviewed the incident reports and found that staff had been present and observing the patient in line with their care plan at the time of each incident and had responded appropriately to safely return the patient to the ward. Staff had also successfully prevented the two further absconsion attempts in the days following the incident. Staff had updated the patient's risk assessments and care plans following each of these incidents and had appropriately mitigated the risk of future absconsion by increasing their observation levels in the garden.

Hospital managers had reviewed the height of the fence in the garden following a serious incident that had taken place on another ward in 2020 but had decided increasing the height would not be necessary as the risk could be managed through the use of individual patient risk assessment and staff observation. Patients could only access the garden with staff supervision and staff implemented additional observations for any patients who were deemed to be at risk of absconding, based on individual risk assessments.

Staff could not observe patients in all parts of the wards. Oak ward was spread over three floors. The lounge, kitchen and therapy rooms were located on the ground floor, and patient bedrooms were located on the first and second floors. Due to the layout, staff could not easily view all areas of the ward. However, staff used convex mirrors to mitigate blind spots in some patient areas, such as the lounge and art therapy room. Staff used individually risk assessed patient

observations to manage the risk in other areas where staff could not easily view patients. Patients had a structured programme of therapeutic activity and meals and spent most of their time on the ground floor during the day. At the time of our inspection, no patients required an enhanced level of observation and so all patients were able to access their bedrooms unsupervised. At night time, a staff member was allocated to be present in patient areas at all times, so they were present to support patients on the second and third floors if needed.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature risk assessments were comprehensive, up to date and accurately identified risks. Patients could not access the kitchen, garden and art room without staff supervision, and we observed these areas were kept locked. Staff mitigated risks in other areas of the ward through patient observation, based on individual risk assessments.

The ward complied with guidance on mixed sex accommodation. Oak ward accepted both male and female patients. Each patient had their own ensuite bedroom. At the time of inspection, all patients on the ward were female, but we were told a male patient was due to be admitted to the ward shortly. The manager had considered arrangements that were required to maintain the dignity of all patients, such as ensuring the male patient would not have to walk past the bedrooms of female patients to reach their own. There was a room on the ward that had been designated as a separate female only lounge, however this room was also used for visits so was not always available for use.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff had a personal alarm which linked to all hospital areas. Each patient had access to a call bell in their bedroom.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Ward areas appeared clean and tidy during our visit and patients told us that a housekeeper visited the ward regularly. However, staff did not always ensure that cleaning records were up-to-date. We found that cleaning records had not been completed since 29 December 2022.

Staff followed infection control policy, including handwashing. Managers completed an infection prevention and control audit for Oak ward every three months. Oak ward had achieved a score of 98% in a recent audit completed in December 2022. Face masks and hand sanitiser were available at the main hospital reception and at the entrance to Oak ward.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. During our inspection of the clinic room we found that staff checked resuscitation equipment every week and took action if they identified any issues. The service had access to a range of different sized equipment to suit all builds including very small individuals.

Staff checked, maintained, and cleaned equipment. The clinic room was visibly clean and tidy. We reviewed three months of cleaning records and saw that these were present and complete. The ward had a clinic room champion who was responsible for auditing the cleanliness of the clinic room. The pharmacist visited the clinic room regularly to check stock levels and the storage of medicines.

Safe staffing

The service had enough nursing staff and managers took action to review staffing levels when this was required. Staff received basic training to keep people safe from avoidable harm.

Requires Improvement

Specialist eating disorder services

Nursing staff

The service had enough nursing and support staff. We reviewed staffing rotas for a 70 day period, between 7 November 2022 and 15 January 2023 and found that staffing levels generally met planned staffing levels. 113 out of 140 (81%) of day and night shifts in this period were staffed to planned levels. The majority of shifts that were not staffed to planned levels occurred between 14 and 27 November 2022. At this time, managers had planned to have 8 staff during the day shift and 7 during the night shift but the level of patient need at the time did not require this level of staff. We saw that managers reduced staffing requirements to reflect this from 28 November 2022. Managers reviewed the staffing levels for each ward during daily flash meetings and were able to adjust staffing levels in relation to patient need.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers used a staffing ladder tool to calculate how many staff were required on each ward and reviewed planned staffing levels during a daily flash meeting. We reviewed flash meeting minutes and saw that the planned staffing level for Oak ward was 5 staff during the day shift and 3 staff during the night shift between 2 and 17 January 2023.

The ward manager could adjust staffing levels according to the needs of the patients. Managers discussed the need for additional staff during the daily flash meeting. We saw that managers had allocated an additional staff member to ensure that there were enough staff to support the ward while one patient received a nasogastric feed.

The service had low vacancy rates. Oak ward had 1.6 vacant posts for a qualified nurse and no healthcare assistant vacancies as of January 2023.

The service had high rates of agency nurses. All night shifts between 3 October 2022 and 30 January 2023 were covered by agency nurses. However, these were regular staff who were familiar with the ward and the needs of the patients.

The service had high but reducing rates of bank and agency nursing assistants. A total of 166 shifts were covered by bank and agency health care assistants in November 2022 but this had reduced to 48 shifts in December 2022 and 23 shifts in January 2023.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank and agency staff received an induction to the ward which included a tour and discussion about how to appropriately support and interact with patients. Regular ward staff had developed a folder which contained essential information and guidance about working with patients with eating disorders.

The service had a low staff turnover rate. The average staff turnover for Oak ward was 2% for 2022.

Levels of sickness were reducing. The average sickness rate for Oak ward was 5% for 2022, this had reduced from a peak of 11% in January 2022. Managers supported staff who needed time off for ill health.

Patients had regular one to one sessions with their named nurse. We saw that named nurse sessions were recorded in the patient records we reviewed. We spoke with three patients who told us they had regular one to one sessions with their named nurse and felt that other staff were also available to provide support when needed.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Most timetabled activities went ahead as planned, however we saw that four psychology group sessions were cancelled in December and January 2023 due to staff absence. Staff and patients told us that escorted leave was rarely cancelled.

The service had enough staff on each shift to carry out any physical interventions safely. Hospital managers reviewed how many staff were trained to use restraint techniques and to deliver immediate life support for each shift during the daily flash meeting and moved staff to support other wards if required. Healthcare assistants monitored patients' physical observations at least twice a day.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us that daily handover meetings were informative and provided essential information. Staff used an electronic handover document to record information about each patient.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Staff told us that the on call doctor was available at night and responded quickly. Managers could call locums when they needed additional medical cover and made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. The overall training compliance for Oak ward was 92% as of 16 February 2023, The provider's target for training compliance was 90%. All individual mandatory training courses had a compliance rate of 75% or above.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included courses such as physical interventions training, Intermediate Life Support, basic life support, safeguarding, fire safety, infection prevention and control and reducing restrictive intervention breakaway training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received an email to remind them when their training needed to be updated. Staff told us that they had enough time to keep up to date with their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint 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 for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed the care records of four patients and saw that each had an up to date risk assessment. We reviewed the risk assessment for one patient who had recently attempted to abscond from the garden and saw that this had been regularly reviewed and updated since the incident. Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff completed a written five point risk assessment with patients each time before they went on leave. This included an assessment of the patient's mental state, compliance with medicines, description of clothing, leave destination and contact details. We reviewed these for

three patients who had gone on leave during our inspection and found these were fully completed and staff knew where the risk assessments were stored on the ward. Though we did see some appropriate blanket restrictions on the ward linked to risk management or treatment, these were all applied appropriately and we did not see any unnecessary restriction in place.

Staff identified and responded to any changes in risks to, or posed by, patients. Oak ward staff discussed and recorded this during handover and multidisciplinary team meetings. Managers from all wards also discussed patient risk during the daily flash meeting.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff kept areas such as the kitchen and art room locked when not in use. They regularly reviewed patient observation levels and adjusted these if there was concern about risk.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff only searched patients when this was considered to be necessary and proportionate, based on individual patient risk assessments. Staff used the five point risk assessment to assess whether a search would be required when individual patients returned from leave.

Use of restrictive interventions

Levels of restrictive interventions were generally low. There were 37 episodes of restraint between January 2022 and January 2023, relating to two patients. Of these, 13 episodes were to prevent one patient from self-harming and 24 episodes involved the restraint of patients to deliver a nasogastric feed. 23 out of these 24 episodes of restraint involved the restraint of one patient and occurred over a three week period. At the time of our inspection no patients required nasogastric feeds and there had been no reported use of nasogastric feeds since November 2022.

There had been no episodes of seclusion between January 2022 and January 2023. Oak ward did not have its own seclusion room and the manager told us that they did not need to use the seclusion room on other wards at the hospital but could access this if it was required.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff demonstrated good knowledge of using verbal de-escalation techniques to reduce the need for physical restraint. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff working in the service were given information around restrictive intervention in eating disorder services and were able to describe risks specific to this service. Eighty one per cent of staff had completed the mandatory reducing restrictive intervention training, other staff were awaiting dates to complete this training. Managers completed an annual restrictive practice audit to review current restrictive practices and consider whether restrictive practices could be reduced.

Staff followed NICE guidance when using rapid tranquilisation. Rapid tranquilisation was rarely used on Oak ward, with one recorded instance between January 2022 and January 2023.We reviewed this incident and saw that the use of rapid tranquilisation had been proportionate, following unsuccessful attempts to use de-escalation techniques. Staff had completed physical health checks following the use of rapid tranquilisation, in line with policy.

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. They knew how to make a safeguarding referral and who to inform if they had concerns. The ward manager was a safeguarding lead, staff were aware of this and told us that the manager provided advice and support around safeguarding issues when required.

Staff kept up-to-date with their safeguarding training. Ninety five percent of staff had completed safeguarding adults and safeguarding children training up to level three.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. For example, one staff member told us how they had escalated concerns to a manager after a patient had made a disclosure about an agency member of staff, this resulted in immediate action to safeguard the patient.

Managers took part in serious case reviews and made changes based on the outcomes. Managers discussed serious incidents in a monthly clinical governance meeting.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. All staff, including bank and agency, had access to the electronic care record system and told us they could easily find the information they needed. Five point risk assessments were completed on paper prior to patients going on leave and stored in the staff office. Staff knew how to access these if needed.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service had a new electronic system in place to manage medicines and staff told us that this worked well and was easy to navigate. An external pharmacy service was used to order stock and to manage patient medicines and a pharmacist undertook regular audits of this system.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed all patients' medicines at least once a week during multidisciplinary meetings and more frequently if needed. Patients were involved in these reviews. Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in the clinic room. We checked ten medicines and saw these were within the expiry date. Controlled drugs were checked and managed appropriately. The pharmacist completed a regular check of medicines to ensure they were within expiry date. Prescriptions were stored on the online system. The pharmacist visited Oak ward weekly and completed regular audits of medicine management.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. We saw that managers had discussed a medicine error that had occurred within a team meeting.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The pharmacist completed regular audits of patient medicines to ensure they did not exceed the British National Formulary (BNF) dose limits. Staff reviewed patient medicines during multidisciplinary meetings and reduced doses of medicines when this was appropriate.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff monitored patients' physical health observations every day for the first seven days of admission and then at least twice a week. We saw evidence of ongoing physical health monitoring in the patient records we reviewed.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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.

There had been 85 incidents on Oak ward between August 2022 and January 2023. Of these, 31 (36%) related to patient self-harm and 26 (31%) related to nasogastric interventions.

There were seven incidents related to patient absconsion. Of these, five were attempted absconsions and two were actual absconsions. Six of these incidents related to the same patient. Staff knew what incidents to report and how to report them. Staff knew how use the electronic incident reporting system. Staff raised concerns and reported incidents and near misses in line with provider policy. We saw evidence that staff completed incident reports when required. Staff reported serious incidents clearly and in line with trust 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. For example, one carer told us that the ward manager had apologised to them after they told them they had not felt fully included in their family member's care and they had been able to resolve the issue.

Managers debriefed and supported staff after any serious incident. Staff told us that they received regular debriefs during weekly reflective practice sessions and following incidents. The staff we spoke with were aware of the incident where a patient absconded in November 2022 and knew of the actions taken following the incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, managers had investigated the incidents of absconsion from the garden area and had sought the views of the patient involved as part of this.

Requires Improvement

Specialist eating disorder services

Although staff received feedback from investigation of incidents, both internal and external to the service, there were limited opportunities for them to discuss this. Staff we spoke with were aware of incidents that had occurred on the ward and within the hospital and told us that they received feedback during team meetings but we saw that team meetings had not happened regularly since August 2022. There had been no team meeting in October, November and December 2022.

Although there was some evidence that changes had been made as a result of feedback ,these were not always effectively implemented. Following a serious incident in 2020, Oak ward had implemented a garden and courtyard risk assessment. This was supposed to include information about previous incidents of absconsion and key lessons learnt from these incidents but it had not been updated to reflect an incident on absconsion and two further incidents of attempted absconsion that had occurred in November 2022. However, staff had appropriately reviewed and updated the patient's individual risk assessment and care plans following these incidents.

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. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff developed a comprehensive care plan for each patient that met their mental and physical health. We saw evidence of this in the four care records we reviewed.

Patients had their physical health assessed within 24 hours of admission and regularly reviewed during their time on the ward. Each patient had their physical health assessed as part of the admission process. Newly admitted patients had their physical health monitored every day for the first seven days of admission and then at least twice a week. Staff increased physical health monitoring if this was required. A formal assessment of nutritional status was carried out by a dietician on admission. Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated. The care plans we reviewed showed evidence of patient voice.

Care plans were recovery oriented; each patient had a planned discharge date and this was reviewed during the weekly multidisciplinary team meetings.

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. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Requires Improvement

Specialist eating disorder services

Staff provided a range of care and treatment suitable for the patients in the service. Oak ward delivered a structured programme five days per week. There were no structured activities at the weekends as many patients went home for leave. However, there were limited activities at weekends for those patients who did not go on leave. One staff member told us that staff tried to do activities with patients on an ad hoc basis and supported patients to go on escorted leave if they had access to this. One patient also told us that they would like more activities to be available at the weekend.

The psychologist delivered compassion focused therapy and an enhanced cognitive behavioural therapy which was designed specifically for patients with eating disorders and in line with national guidance from the National Institute for Health and Care Excellence (NICE). The treatment programme consisted of two group sessions per week and one individual session per week.

The occupational therapist delivered group and individual sessions, depending on individual need. They provided a weekly life skills and coping strategy group, a weekly community outing and individual food exposure sessions. Two patients told us that they would like the opportunity to engage in more OT sessions in the community.

Staff identified patients' physical health needs and recorded them in their care plans. We saw evidence of this in the care plans we reviewed. Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. The dietician assessed each patient as part of the admission process and reviewed dietary needs at the weekly multidisciplinary team meeting.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had a body image specialist who delivered a body image group once a week.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used outcome measures including the Eating Disorder Examination Questionnaire (EDE-Q) and Health of the Nation Outcome Scale (HONOS).

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, managers completed a weekly check of rotas, staff training and care plans. A manager from another ward visited Oak ward to complete a monthly walkaround audit to review documentation, the environment and staff and patient interactions. They provided feedback to the ward manager.

Managers used results from audits to make improvements. For example, the ward manager had emailed a nurse to inform them of issues that were picked up during a care plan audit.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. 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 the patients on the ward. The multidisciplinary team consisted of nurses, healthcare assistants, dieticians, an occupational therapist, specialist EDU therapist, psychologist and consultant. Staff told us that it was easy to contact other members of the multidisciplinary team outside of the weekly meeting.

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 checked that agency staff had completed the relevant mandatory training before they were employed to work on the ward.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us that they had time to complete mandatory training and to shadow staff during their induction.

Managers supported staff through regular, constructive appraisals of their work. All eligible staff had received their annual appraisal in 2022.

Managers supported staff through regular, constructive clinical supervision of their work. Eighty-four per cent of all staff received supervision in December 2022.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they discussed development opportunities in their supervision sessions.

Managers ensured that staff received specialist training for their role. For example, qualified staff had access to and completed nasogastric training. All staff attended an annual training day with other services within the Priory eating disorders network. However, newer staff had not yet accessed this. The service had developed a new four day specialist eating disorder course and the ward manager was in the process of booking staff onto this.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers monitored the performance of staff in regular supervision sessions.

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 team 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. Multidisciplinary meetings took place weekly on Oak ward. These were attended by a range of staff including nurses, the psychologist, occupational therapist, dietician and consultant.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings took place twice a day, at the start of each shift. Staff completed a handover template for each patient and recorded this in their electronic care records. Staff told us that the handover was useful and provided the key information they needed.

Ward teams had effective working relationships with other teams in the organisation. Managers from each ward attended a daily 'flash' meeting, where issues around incidents and staffing levels were discussed. Managers for each ward met monthly to discuss and share information.

Ward teams had effective working relationships with external teams and organisations. The ward manager told us that they had good links with the West Midlands Adult Eating Disorder Provider Collaborative. This is a partnership between

local eating disorder providers. The ward manager told us that they attended a weekly meeting with other providers within the collaborative to discuss new referrals. Staff also invited community case managers to attend care pathway approach (CPA) meetings for patients. We observed that the community case manager attended a CPA meeting for one patient during our inspection.

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. Ninety five per cent of staff had completed and were up to date with Mental Health Act training and could describe the Code of Practice 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 Mental Health Act administrator attended the daily flash meeting to provide updates and advice as needed.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The advocate's details were displayed on the ward. The advocate attended the ward weekly and provided telephone or drop-in support as required. We saw that the advocate regularly attended the community meeting.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We reviewed the care record for two patients who were detained and saw that staff regularly explained their rights under the Mental Health Act.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients told us that staff ensured they were able to take their leave. Due to the comprehensive treatment programme that was in place five days a week, patients were only permitted to take unescorted leave at weekends. Staff ensured patients were aware of this prior to their admission to the ward.

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. The Mental Health Act administrator stored these securely in an office away from the ward.

Informal patients knew that they could leave the ward freely and the service displayed posters in communal areas and on doors to tell them this.

Requires Improvement

Specialist eating disorder services

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Managers completed an annual audit of the Mental Health Act and discussed the findings of these in their monthly manager meetings. For example, all ward managers sent a weekly email to nurses highlight patients who needed to be informed of their Mental Health Act rights.

Good practice in applying the Mental Capacity Act

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

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. Ninety five per cent of staff had completed training on the Mental Capacity Act at the time of our inspection.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew that they could find this policy on the provider's intranet page.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff sought advice about the Mental Capacity Act from the ward manager when they needed to.

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 clearly each time a patient needed to make an important decision. For example, staff assessed and recorded capacity to consent to treatment at the point of admission and regularly reviewed this. Staff had appropriately assessed and recorded one patient's capacity to self-discharge from the service and had given them information about the risks of this.

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.

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.

We spoke with three patients during inspection. All patients told us that staff were kind, discreet, respectful, responsive and treated them well. We observed positive interactions between staff and patients during the inspection.

Requires Improvement

Specialist eating disorder services

Staff supported patients to understand and manage their own care treatment or condition and gave patients help, emotional support and advice when they needed it. For example, patients told us that staff continued to provide advice and support when they were away from the service on leave. Staff understood and respected the individual needs of each patient.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported two patients to continue to attend therapy sessions with external providers during their admission and incorporated this into their treatment plans.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us that the ward manager was very approachable, and they felt able to raise concerns.

Staff followed policy to keep patient information confidential. During a community meeting we observed that staff and patients discussed ways to keep patient information confidential, following concerns raised that patients could overhear staff talking about patients in the office. Staff and patients mutually agreed that patients would wait in the lounge after knocking on the office door, to ensure that patients did not overhear confidential information.

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 and the services as part of their admission. The ward had developed an induction pack to give to new patients when admitted to the ward. This was based on patient feedback and included information about the purpose of the ward and some sensory equipment.

Staff involved patients and gave them access to their care planning and risk assessments. All three patients we spoke with told us that they had been given a copy of their care plan and had been involved in the creation of their care plans. We also saw evidence of patient involvement in the four care records we reviewed. However, one patient told us that felt they had not had meaningful input into their care plan as staff had just asked them to sign if they were in agreement with the contents of the care plan, rather than co-producing the care plan with staff.

Staff made sure patients understood their care and treatment. Staff involved patients in weekly multidisciplinary meetings and were encouraged to share their views and ask questions about their care and treatment.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us that the multidisciplinary team provided them with surveys to gather their views on their treatment. Staff sought patients' views and involved them in decisions during weekly community meetings.

Staff made sure patients could access advocacy services. Staff displayed advocacy posters in communal areas. The advocate was invited to attend weekly community meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Requires Improvement

Specialist eating disorder services

Staff supported, informed and involved families or carers. We observed a multidisciplinary team meeting and saw that staff had invited a carer to attend. Four other carers told us that they were regularly invited to attend meetings. Carers told us that staff were supportive and kept them informed. They told us that staff also provided support and reassurance when their family member visited home at the weekends.

Staff helped families to give feedback on the service. Two carers told us they had been able to raise concerns directly with the ward manager who had listened and responded appropriately to their concerns. Staff had planned to deliver a monthly carers group, which would be available for carers up to two months post-discharge. Carers had the option to join the meeting in person or online. Four out of five carers we spoke with told us that they had been invited to the first of these sessions, scheduled for March 2023.

Staff gave carers information on how to find the carer's assessment. The hospital had access to a social work team and staff told us they could refer carers for a carers assessment if required.

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 have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay between 1 November 2022 and 31 January 2023 was 74 days. Staff actively worked with patients, their families and local community teams to plan for discharge.

The service had low out-of-area placements. Oak ward was part of the West Midlands Adult Eating Disorders Provider Collaborative, which managed all eating disorder beds in the region. This aimed to ensure patients were treated as close to home as possible. As a result, all patients on Oak ward at the time of the inspection lived locally.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. Most patients went on home leave at the weekends and their bed was always available when they returned to the ward.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. The ward had worked with the provider collaborative to find a local acute bed for a patient who experienced a significant decline in their mental health. The ward manager told us that patients rarely needed to transfer to the onsite psychiatric intensive care unit. Staff did not move or discharge patients at night or very early in the morning.

Requires Improvement

Specialist eating disorder services

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The ward manager and consultant attended a weekly bed management meeting with the provider collaborative to discuss the progress of patients who were working towards discharge. Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We observed a care pathway meeting and saw that the patient, their family and their community team attended this.

Staff supported patients when they were referred or transferred between services. Oak ward had planned a monthly carers group that provided support for the carers of current patients and for up to two months after discharge. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. Patients could make hot drinks and snacks with staff supervision. However, the ward had limited quiet areas for privacy and patients and carers told us that the food was not always of good quality.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. Patient bedrooms contained storage including a wardrobe, draws, desk and cabinets.

Although staff had access to rooms and equipment to support treatment and care, the number of rooms available was limited. The ward had an art room, lounge and another communal room called the garden room. Staff and patients told us that many of these rooms were multipurpose. For example, the lounge was used for staff to complete post-mealtime supervision of patients, which was part of the treatment plan. All patients had to be supervised in the lounge for 1 hour after every meal and for 30 minutes after every snack. The lounge was quite small, and one patient told us that it could feel cramped during post meal supervision.

The service had a room where patients could meet with visitors, but this was not always private. Visits took place in the garden room. Two patients and a carer told us that their visits were sometimes interrupted by staff walking through the room to access the outdoor areas. Whilst it was the patients choice to have the visit in this area, it meant that the patient and their visitors privacy was not maintained as staff had to walk through this area. The ward had limited quiet areas.

Patients could make phone calls in private. Patients had access to mobile phones and could make calls in their bedrooms.

The service had an outside space that patients could access easily. Staff supervised patients when they used the ward garden to ensure patients were kept safe. The level of supervision was based on individual risk assessments.

Patients could make their own hot drinks and snacks in the ward kitchen. Patients' access to the kitchen was managed by staff as part of the treatment programme. The kitchen was kept locked, but patients could access this with staff supervision.

The service offered a variety of food, but this was not always of good quality. Carers we spoke with raised concerns about the food quality and patients had raised concerns about food quality during community meetings. The ward manager had discussed the concerns with the catering department and had requested that the menu was changed at a clinical governance meeting. Staff told us that the menu did not change very often and lacked variety.

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, and supported patients. However, two of the three patients we spoke with told us that they would like more activities to be available on the ward and to have more opportunity to go out into the community with the occupational therapist during the week.

Staff helped patients to stay in contact with families and carers. Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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 needs or other specific needs. The ward had a lift and was accessible for wheelchair users and for patients with mobility issues. We saw that staff had worked with one patient to develop an effective communication strategy using coloured wristbands to express mood, based on their needs and preferences.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This information was displayed in communal ward areas. Each patient was given this information as part of their induction to the ward.

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. Staff could provide information in other languages when this was needed.

The service provided a variety of food to meet the cultural needs of individual patients. However, staff told us that it was more difficult to provide food that reflected preference or personal choice.

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. Three carers told us that felt able to raise any concerns they had directly with the ward manager, who they described as approachable and dedicated.

The service clearly displayed information about how to raise a concern in patient areas. We saw that this information was displayed in communal areas.

Requires Improvement

Specialist eating disorder services

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. Staff informed patients of relevant complaints during the weekly community meeting and offered debriefs when this was required. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers investigated complaints and identified themes. The main theme of patient complaints related to food quality. We saw that the manager had raised this with the catering team and in a clinical governance meeting. Work to review the ward menu was ongoing. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff had listened to feedback from patients about how they found it difficult when at home for Christmas to sit and eat a Christmas dinner. So staff held a 'mock' Christmas dinner to support patients to reduce and manage stress when they are at home.'

The service used compliments to learn, celebrate success and improve the quality of care. Staff celebrated success by nominating a patient of the week during community meetings. We observed that staff and patients came together to celebrate when a patient was discharged. This helped to promote a recovery focused ethos.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. 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.

Staff told us that they felt well supported by the ward manager. The ward manager had a good understanding of the service and of the needs of patients. Most staff knew who the members of the senior leadership team were and told us they visited the ward.

Vision and strategy

Most staff knew and understood the provider's vision and values and how they were applied to the work of their team. For example, staff could describe how they fulfilled the values of putting people first and being supportive in their work.

Senior leaders met monthly to discuss a variety of issues, including staffing levels and risk and shared this information within their teams.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Requires Improvement

Specialist eating disorder services

Overall, staff were proud to work for the organisation and told us they felt respected and valued by their leaders and worked well as a team.

Staff felt able to raise concerns with the ward manager and knew how to use the whistleblowing process.

Staff told us that they had opportunities to progress in their roles, and managers discussed opportunities with individuals during supervision and appraisal meetings.

Governance

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

Although staff received feedback about incidents that occurred both internal and external to the service, we were concerned that this meant that staff had limited opportunity to discuss and learn from incidents. Team meetings had not taken place regularly, there had been no meeting in November and December 2022.

There was no effective process in place to ensure that staff updated the garden risk assessment in line with the provider's policy following an incident of a patient absconding from the service and further attempts in November 2022. Managers had identified the need to update the garden risk assessment as an action following the absconsion but this had not been completed. We were concerned that the overall risk level of the garden area had not been reviewed following these incidents which meant appropriate action could not be taken to reduce future risk for all. However, we saw that staff had updated the patient's individual risk assessment and care plan after each incident.

Managers and staff took part in regular audits to assess the quality of care provided on the ward. However, managers had not ensured that housekeeping records were up to date. Although ward and patient areas appeared clean during our visit, housekeeping records had not been completed since 29 December 2022 so it was not possible to ascertain how regularly cleaning took place and to what standard.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the hospital risk register and had ensured that risks specific to Oak ward had been recorded on it. Risks identified by ward staff reflected those on the risk register. For example, the risk of absconsion from the Oak garden area was included on the hospital risk register. Staff had access to the risk register.

Managers reviewed risk and staffing levels at the daily flash meeting and escalated concerns when required.

Information management

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

Staff had access to the equipment and information technology they needed to complete their work and were able to access the electronic patient recording system.

Staff made notifications to external organisations such as CQC or the local authority safeguarding team as needed.

Requires Improvement

Specialist eating disorder services

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers regularly met with other providers in the West Midlands Adult Eating Disorder Provider Collaborative to consider referrals and to enable the collaborative to review bed availability across the region.

Staff received up to date information about the work of the provider in weekly information cascade emails, and staff then shared relevant information with patients during community meetings. Staff had planned a monthly carers support group to keep them updated with the work of the provider.

Patients and carers were able to give feedback about the service. Staff supported patients to access advocacy support.

Learning, continuous improvement and innovation

Staff had opportunities to participate in research. For example, the psychology department was due to commence a research project to evaluate the effectiveness of a dialectical behavioural therapy (DBT) informed coping skills group.

Oak ward was accredited with the Quality Network for eating disorders.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure that leaders and managers have oversight of, and act on concerns regarding ward environments, and fire safety and evacuation procedures. The service must ensure that cleaning records are completed and kept up to date, in line with the provider's policy. The service must ensure that team meetings occur regularly to ensure staff have opportunities to discuss the outcomes of incidents and for managers to provide updates regarding any changes in ward processes. Managers must ensure agency induction checklists are fully complete. Managers must ensure they have sufficient and effective systems and processes to ensure that medical equipment and devices stored in the clinic room are kept in date, calibrated and cleaned regularly

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that ward environments are clean and adhere to infection prevention and control standards and guidance. The service must ensure the treatment room and specimen fridge is clean, they are checked for out of date items and items in the clinic room are calibrated regularly and this is documented.

This section is primarily information for the provider

Requirement notices

The service must ensure all staff have access to, and regularly update all copies of children and young people's care plans and risk assessments.

The service must ensure staff follow the provider's policy and procedures on the use of enhanced support when observing children and young people.

Managers must ensure staff review and take appropriate action with regards to children and young people's paediatric early warning score (PEWS) records and escalate concerns where necessary.

The service must ensure that there are robust fire safety and evacuation procedures in place including up to date and individualised personal emergency evacuation plans.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service must ensure that it makes reasonable adjustments for patients with a diagnosis of autism. This must include ensuring appropriate care plans are in place and sensory and dietary needs are met.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service must ensure that the design, layout, and furnishings of wards are properly maintained. The service must ensure that the seclusion suite has a working intercom to enable two- way communication between staff and patients.