The Retreat - York

Quality Report

107 Heslington Rd
York
YO10 5BN
Tel: 01904 412551
Website: www.theretreatyork.org.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The Retreat York as **good** because:

- The organisation had made improvements following feedback from our previous inspections. Staff made changes to systems and processes across the organisation, and improvements meant patients received safe care and treatment. The unit managers had a good understanding of their units and shared good practice.
- Staff were respectful and courteous at all times. Staff treated patients with dignity and respect and saw each patient as an individual. Staff involved patients, carers, and advocates in decisions about their care and treatment and took account of patients' preferences and advance decisions. Staff helped patients engage with their environment and take part in meaningful activities.
- Staff completed detailed, personalised care plans, which included crisis plans and information about their mental and physical health needs. Care plans took account of best practice guidance and patients and carers were involved in decisions about their care. Patients' physical health care concerns were addressed.
- Units held effective handovers and multidisciplinary team meetings to review and discuss patient care and treatment. Staff adherence to the Mental Health Act and Code of Practice was good overall and staff understood how to apply the Mental Capacity Act.
- Staff were trained in safeguarding and incidents, they knew how and when to raise alerts. Staff completed and reviewed comprehensive individual and environmental risk assessments that kept patients safe. There were governance arrangements in place to monitor and respond to trends.
- The units had good medicines management arrangements that meant staff stored, monitored, and administered medication safely. Medicines were managed in a safe way and patients were risk assessed to be self-medicating.
- The leadership and culture of the units reflected the organisation's vision and values. Staff knew who their senior managers were and spoke highly of the support they offered. Senior managers from the senior leadership team visited units and attended team meetings to listen to staff concerns and keep staff informed of service developments.
- Morale on the units had improved following recent unit and senior management changes. Staff felt able to raise their concerns and that managers would listen to them and take appropriate action. Staff spoke positively of the senior management team and the positive changes they had made.

However,

- The majority of staff lower than the middle management tier were not involved or aware of the emerging improvement strategy for the organisation.
- Staff on Kemp unit did not appropriately use section 5(4) of the Mental Health Act to prevent patients leaving the hospital at a time when it was deemed unsafe for them to do so.
- Staff on the older adult units were not clear what arrangements were in place for individual patients when authorisations for Deprivation of Liberty safeguards were delayed.
- The provider did not have a consistent approach to the review of restrictive practices and we did not see processes that reviewed if lessons learnt had been embedded in the organisation following a complaint or incident.
- The older adult service had no clear model of care or discharge pathway. The provider was aware of this and was reviewing the clinical model as part of its emerging strategy.
- Patients from Naomi unit told us that there wasn't a room on the unit where they could meet with visitors. The bedroom doors on older adult units compromised patients' privacy, dignity, and confidentiality. The dining room on Katherine Allen was not large enough to accommodate all patients in one sitting.
- Older adults units could not assure us that they checked all equipment to ensure it was safe to use. Both units had not carried out a recent fire drill to test that their procedures were safe.
- Electronic records related to medication management had not been consistently documented by agency staff on older adult units.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Good	
Specialist eating disorders services		Inspected not rated
Personality disorder services		Inspected not rated

Summary of findings

Contents

Good

The Retreat - York

Services we looked at

Wards for older people with mental health problems; Specialist eating disorders services; Specialist personality disorder units;

Summary of this inspection

Background to The Retreat - York

The Retreat York was established in 1796 and is an independent specialist mental health care provider for treatment of up to 98 people with complex mental health needs. The service is located on a forty acre site on the outskirts of York. The main building is Grade II listed with a range of their buildings situated in the grounds.

The main building consists of five units across three services:

Units for older people with mental health problems

- George Jepson unit is a 13 bed unit located on the ground floor that provides specialist care and treatment for men who have a primary diagnosis of a functional or organic disorder such as dementia and other disorders. It supports patients who may have challenging behaviour.
- Katherine Allen unit is a 12 bed unit situated on the first floor which provides specialist older adult care for women with functional or organic disorders such as depression or psychosis or dementia. It supports patients who may have challenging behaviour.

Specialist eating disorders services

- The Naomi unit is a 15 bed specialist eating disorder unit for women with complex needs situated on the first floor. The team specialise in treating women with more than one diagnosis, which may include personality disorders, obsessive compulsive disorder and complex post-traumatic stress disorder. Naomi unit is a modified therapeutic community that uses a programme of group and individual therapy to help people take responsibility for their own recovery.

Specialist personality disorder units

- The Kemp unit is a 10 bed personality disorder unit for women with severe and complex personality disorder with a focus on borderline personality disorder, dissociation and dissociative identity disorder. Treatment includes the management of co-morbid conditions such as addictions and eating disorders.
- Acorn unit is a 12 bed therapeutic environment for women meeting the criteria for borderline personality disorder, dissociative disorder and complex post traumatic stress disorder.

We have reported on all five units in this report.

The Retreat York has been previously inspected on eight occasions. This is the third inspection of the provider as part of our ongoing comprehensive mental health inspection programme.

The most recent inspection was an unannounced responsive focused inspection of the George Jepson older adults unit. The service was previously rated inadequate overall. On 13 February 2017 we inspected after the provider informed us that 13 safeguarding alerts had been reported to them by two staff members. The alerts related primarily to staff delivery of patient personal care, inappropriate moving and handling of patients, and staffing shortages. These alerts also contained reports of bullying within the staff team. The reported incidents had occurred during the period the 11 January 2017 to 3 February 2017 when six patients from George Jepson unit were moved to another unit, the 'Allis' unit , while refurbishment work took place on the George Jepson unit.

We issued one requirement notice and two warning notices in relation to the Health and Social Care Act 2014 regulations:

- Requirement Notice: Dignity and Respect - The provider did not ensure that each person's privacy must be maintained at all times including when they are asleep, unconscious or lack capacity.
- Warning Notice: Safeguarding service users from abuse and improper treatment -The provider did not ensure that systems and processes were established and operated effectively to prevent abuse of service users.
- Warning Notice: Good governance - The provider did not ensure that they had assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users which arise from the carrying on of the regulated activity. The provider did not ensure that the system included scrutiny and overall responsibility at board level or equivalent. The provider did not ensure they operated effective

Summary of this inspection

systems and processes to make sure they assessed and monitored their service against regulations in response to the changing needs of people who use the service.

The previous comprehensive inspection on 29 November 2016 rated The Retreat York as requires improvement overall. We issued three requirement notices in relation to the Health and Social Care Act 2014 regulations:

- Person-centred care - The provider did not ensure that on older people's units, the care and treatment of all service users was appropriate and met patients' individual needs.
- Safe care and treatment -The provider did not ensure that staff responsible for the management and administration of medication were suitably trained, competent and reviewed. Staff were not following policies and procedures about managing medicines, including those related to infection control.
- Staffing -The provider did not ensure that all staff received appropriate support, professional development supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The Care Quality Commission adult social care team inspected the Cottage and East Villa on 1 and 7 December 2016 and rated the service as good overall. The service met the Health and Social Care Act (Regulated Activities) Regulations 2014 and had addressed issues identified in the previous inspection.

The Care Quality Commission adult social care team previously inspected Cottage and East Villa on 7 June 2016. The inspection team found several areas of concern including: admission of people to the service without 'best interest' decisions, use of restraint techniques for prolonged periods of time, seclusion behind locked bedroom doors, inappropriate use of hand held restraint for the purposes of providing personal care and people only having access to the local community with two-to-one support.

There was an inspection on 27 October 2015 of units for older people with mental health problems, specialist eating disorders services and the personality disorder therapeutic community that resulted in a requirement notice. In October 2015, we found that the provider had not ensured the proper and safe management of medicines by ensuring they were stored at a safe temperature, disposing of unwanted medicines safely and ensuring that patients who were prescribed as and when required medicines had a clear record of the reasons for this. We found that patients at risk of falls did not have comprehensive plans in place to mitigate this risk including wearing safe footwear. We also recommended that the provider should ensure that activities were provided on the units for older people that met the needs of people with dementia; that the provider should ensure that staff were well informed about internal whistle-blowing processes; and that the provider should ensure that on the units for older people they should always have a record of the care co-ordinator to assist with discharge planning.

There was a focused inspection of the George Jepson unit on 10 May 2015. The inspection followed an anonymous whistle blowing concern and safeguarding investigation. The inspection identified staffing shortages and was reported within the 27 October 2015 inspection report.

There have also been four Mental Health Act monitoring visits in the past 14 months.

The Mental Health Act visit to the George Jepson older people unit was on 13 September 2017. They found blanket restrictions in relation to outside access, a choice of snacks and drinks were not left out for patients, patients did not have access to keys for their own bedrooms or lockable space for personal belongings, care plans did not contain evidence of patients' views or that staff involved carers in patients' care plans or evidence of discharge planning, little evidence of activities taking place and the unit did not have records about patients' physical health checks or have all the appropriate documentation for section 17 leave such as patients' or relatives signatures and risk assessments relating to leave. These issues were now resolved.

The Mental Health Act visit to Kemp unit was on 15 December 2016. They found that some rooms were locked on the unit and patients had to ask staff to open the doors. There was no clear explanation why these rooms were unavailable to patients. Patients' rights were read approximately every three months however there was an occasion where there was no recorded rights for a patient when they had been subject to nurses holding powers. The Mental Health Act reviewer could not also

Summary of this inspection

see any evidence that the responsible clinician had assessed patients' capacity to consent to treatment at first administration of medication, but capacity assessments were in evidence at the start of the 'three-month rule'. They could see no evidence in the notes where the patient's view of how leave went was recorded. These issues were now resolved.

The last Mental Health Act visit to Katherine Allen older people unit was 26 October 2016. The Mental Health Act reviewer found that informal patients were not aware of their right to leave the unit, the environment was not dementia friendly and did not protect patients' dignity and confidentiality, medical staff did not document reviews and assessments of patients' capacity to consent to treatment and review of treatment and section 17 leave forms were not person centred and did not reflect the patient's perspective of how they felt the leave went. These issues were now resolved.

The Mental Health Act visit to Naomi eating disorder unit was on 19 September 2016. The Mental Health Act reviewer found that the unit did not automatically refer patients lacking capacity to the advocacy service. During our inspection no patients lacked capacity but the unit told us that a form had been implemented to complete the referral when a capacity assessment had been completed. The Mental Health Act visit also identified a blanket restriction on the use of the activities of daily living kitchen which was used by patients to practice skills relating to meal preparation and cooking. The unit had told us they had resolved this by individually risk assessing patients for access.

At this comprehensive inspection in November 2017, we found that all units had taken action that addressed all the issues from our previous inspections.

The Retreat York has been registered with the Care Quality Commission since October 2010 to provide the following regulated activities:

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

The hospital had completed an application to the Care Quality Commission to register their interim director of operations as registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. They also had a controlled drug accountable officer at the time of inspection. A controlled drugs accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

Our inspection team

The team that inspected the service comprised one lead Care Quality Commission inspector, an additional three Care Quality Commission inspectors, an inspection manager, a member of the medicines management team, an assistant inspector and a range of specialist advisors: a psychologist, a consultant psychiatrist, two board level directors, one occupational therapist, one registered nurse with experience in older adult care, one registered nurse with experience in eating disorders, one registered nurse with experience in personality disorders and one older adult expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

Summary of this inspection

Why we carried out this inspection

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

At the last inspection in February 2017, we rated wards for older people with mental health problems as 'inadequate' overall. We did not inspect specialist eating disorders and personality disorder services on this occasion as we completed a responsive focused inspection of the George Jepson unit only.

At the previous inspection in November 2016, we rated wards for older people with mental health problems as 'requires improvement' overall. We inspected but did not rate specialist eating disorders and personality disorder services provided at the Retreat York.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked the local authority, commissioners, advocacy services, NHS Improvement and Healthwatch for information and sought feedback from staff and the board of trustees the week prior to the inspection via focus groups.

During the inspection visit, the inspection team:

- visited all five units at the hospital, looked at the quality of the unit environment and observed how staff were caring for patients;
- spoke with 26 patients who were using the service;
- collected feedback from four patients and four members of staff using comment cards;
- observed one mealtime and post meal support group;
- spoke with the acting registered manager and unit managers for each of the units;
- spoke with 23 other staff members; including doctors, nurses, support workers occupational therapists, psychologists, social workers and directors;
- received feedback about the service from the local authority, commissioners and advocacy services;
- spoke with 14 carers and family members;
- spoke with one board member and held a focus group for the trustees;
- attended and observed two handover meetings;
- attended and observed three patient activity sessions;
- looked at 25 care and treatment records of patients;
- carried out a specific check of the medication management on all units;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with one patient and nine carers about the service on the older persons units. The overall response was very positive. Most carers commented on the individualised care their relative received from kind and caring staff. Carers felt that staff understood their relative very well and felt confident that their relative received safe care and treatment. Carers felt involved in decisions about their relatives care and treatment and felt staff kept them informed about decisions affecting the service.

We spoke with five patients and one carer from the eating disorder unit who told us they felt safe on the unit. Patients described the staff as supportive and approachable even when they were being challenged

Summary of this inspection

about their eating disorders. Patients told us that staff acted calmly and professionally at all times. We received one comment from a patient saying the staff were very helpful and could not do enough to help.

Patients on the personality disorder units told us that staff were polite, kind and respectful. They told us that staff displayed humanity and understanding for their issues and looked at flexible and creative approaches to help them with long standing issues. Patients told us that they had good support from their named nurse or key worker. They all said they were involved in the recruitment of staff and the involvement team.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- The organisation had made improvements following feedback from our previous inspections. Staff made changes to systems and processes across the organisation, and improvements to the environment on George Jepson meant patients received safe care and treatment.
- The organisation provided safe environments and managed risks well. Staff completed and reviewed comprehensive individual and environmental risk assessments that kept patients safe. There was enough staff to carry out observations and spend time with patients. Risk was discussed in multidisciplinary team meetings, formulation meetings and handovers.
- We observed the units to be clean and well maintained with good infection control measures in place.
- With the exception of Kemp unit there was enough staff on duty with the right skills and experience for their roles. Kemp unit had recognised this as an issue and was working with the human resources department to facilitate a resolution.
- New staff, including agency staff, were required to have an induction to familiarise them with the unit and patient group. There were enough staff on the unit so that leave and therapy sessions were completed as planned.
- Staff were trained in safeguarding and incidents, they knew how and when to raise alerts; safeguarding concerns fed into the incident reporting system. Unit managers discussed incidents that met the duty of candour threshold at daily unit manager meetings and a communication log was kept and monitored by the governance department. Provider level changes were visible following incidents.
- Staff knew their patients well and used positive behaviour support plans to reduce the risks of aggression. Staff understood that the use of restraint was a last resort and used de-escalation and low levels of restraint to manage incidents of aggression. Carers told us they felt staff kept their relatives safe.
- The units had good medicines management arrangements that meant staff stored, monitored, and administered medication safely. Medicines were managed in a safe way and patients were risk assessed to be self-medicating.

However;

Summary of this inspection

- Mandatory training compliance did not meet the provider target for all staff on all units.
- Older adults units could not assure us that they checked all equipment to ensure it was safe to use. Both units had not carried out a recent fire drill to test that their procedures were safe.
- Electronic records related to medication management had not been consistently documented by agency staff on older adult units.

Are services effective?

Good

We rated effective as **good** because:

- Patients received a physical assessment on admission and there was evidence of ongoing physical health monitoring. Patients had access to specialists when needed.
- The Mental Health Act advisor had comprehensive monthly audits in place for use of urgent treatment, holding powers and temporary holds on informal patients. The service kept clear records of leave granted to patients. Patients could access independent mental health advocates
- Staff completed detailed, personalised care plans, which included crisis plans and information about their mental and physical health needs. Care plans took account of best practice guidance and involved patients and carers in decisions about their care.
- The provider ensured that staff were appraised and had access to regular team meetings and support when needed. Staff received specialist training appropriate for their role and managers addressed any staff performance issues promptly.
- Staff held effective handovers and multi-disciplinary team meetings to review patient care and treatment. Staff adherence to the Mental Health Act and Code of Practice was good and staff understood how to apply the Mental Capacity Act. Staff completed capacity assessments and documented best interest decisions for patients who lacked capacity.

However;

- Staff supervision rates were low across the organisation for one to one sessions. Group supervision and informal supervision occurred but was not always recorded.
- Authorisations for patients who were subject to Deprivation of Liberty safeguards were delayed and staff on the older adult units were not clear what arrangements were in place for individual patient applications.

Summary of this inspection

- Staff on Kemp unit did not appropriately use section 5(4) of the Mental Health Act to prevent patients leaving the hospital at a time when it was deemed unsafe for them to do so.

Are services caring?

Good

We rated caring as **good** because:

- Staff were respectful and courteous at all times. Staff treated patients with dignity and respect and saw each person as an individual.
- Patients described the staff as supportive and approachable even when they were being challenged about their conditions. Patients told us that staff acted calmly and professionally at all times.
- There was a comprehensive admissions process for patients.
- Patients held weekly business meetings where they were able to feedback and raise any issues on the service. Patients felt that they could raise issues outside of this forum and would speak to the staff or unit manager directly.
- Staff involved patients, carers, and advocates in decisions about their care and treatment and took account of patients' preferences and advance statements.
- We observed very kind and caring communication when staff interacted with patients. Staff used their knowledge of individual patients to help patients engage with their environment and take part in meaningful activities.
- Patients were involved in all aspects of their care and staff only shared information with families, partners and carers when the patient indicated they could.

Are services responsive?

Good

We rated responsive as **good** because:

- Patients were admitted to the units from all over the country and staff kept in regular contact with the home teams responsible for the patient's care. Staff supported patients' recovery and documented discharge discussions for all patients.
- The units had a full range of rooms and equipment to support patient care and treatment. Staff recognised the mixed needs of patients and created environments that were personalised and comfortable; older adult units were also dementia friendly. There was a timetable of activities that accommodated the individualised needs of the patients.

Summary of this inspection

- Staff supported the needs of all people who used the service including people with disabilities and specific communication and spiritual requirements. There was a good choice of food available to suit patients' preferences, religious and health needs.
- Admissions and discharges were planned and managed in a timely manner on eating disorder and personality disorder units.
- Patients knew how to make a complaint and all complaints were investigated.

However;

- We did not see processes that reviewed if the lessons learnt had been embedded in the organisation following a complaint.
- The older adult service had no clear model of care or discharge pathway. The provider was aware of this and was reviewing the clinical model as part of its emerging strategy. Some patients remained on the unit for many years and delays to discharge occurred because of lack of available placement and funding issues.
- The bedroom doors on older adult units compromised patients' privacy, dignity, and confidentiality. The dining room on Katherine Allen was not large enough to accommodate all patients in one sitting. Some patients on George Jepson chose to eat in the corridors and other rooms where staff were not immediately present.
- Patients from Naomi unit told us that there wasn't a room on the unit where they could meet with visitors; this was difficult when they didn't feel comfortable having visitors in their bedrooms.

Are services well-led?

Good

We rated well-led as **good** because:

- The leadership and culture of the units reflected the hospital vision and values. Staff knew who their senior managers were and spoke highly of the support they offered. Senior managers from the hospital visited the units to listen to staff concerns and keep staff informed of service developments.
- The unit managers had a good understanding of their units and were committed to making continuous improvements to the service. They had started to work together to share ideas and good practice to make improvements. They understood the hospital governance systems and processes and contributed to senior manager forums to report on the unit's performance.

Summary of this inspection

- Staff told us that morale on the units had improved following recent unit and senior management changes. Staff felt confident to raise their concerns and that managers would listen to them and take appropriate action.
- Actions identified from the staff survey had a designated lead and progress was monitored at weekly leadership team meetings and discussed with trustees of the board
- The provider had recently restructured their risk register process so that all units had an individual unit risk register which escalated relevant risks to the corporate register.

However;

- Staff we spoke with were not involved or aware of the emerging improvement strategy for the organisation.
- The provider did not have a consistent approach to the review of restrictive practices.
- The provider did not fully comply with Workforce Race Equality and Accessible Information standards.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All inpatient units, with the exception of Acorn unit which did not admit detained patients for longer than a two week period, had received a Mental Health Act monitoring visit over the 14 months prior to the inspection.

The provider had employed a Mental Health Act Law Advisor who oversaw all matters relating to the Mental Health Act. Mental Health Act Law Advisor also provided training and advice for unit staff. Overall training in the Mental Health Act and Code of Practice was 96% which exceeded the Retreat York's compliance target.

Patients detained under the Mental Health Act were made aware of their rights on a regular basis. Informal patients were informed of their rights on admission however, patients on Naomi unit told us they were not updated regularly once admitted. Older adults units were locked, but only one unit displayed a notice that informed informal patients how they could leave the unit. At the time of our inspection, all patients on older adults units were detained under the Mental Health Act or Deprivation of Liberty Safeguards. Staff supported patients to leave the unit such as to access activities and authorised leave when required.

Patients were supported to access local independent mental health advocates and were able to appeal against their section at tribunal and take section 17 leave.

We reviewed the files of 12 patients detained under the Act and found documentation to be well structured, organised and complete.

Staff carried out audits that checked they adhered to the Mental Health Act and Code of Practice and took action where required. Staff ensured that the right authorisation was in place to administer medication and kept T2 and T3 forms in good order. Staff had acted to make changes to the Section 17 leave form in response to concerns raised by previous Mental Health Act review visits on the older adults unit. Staff on Kemp unit did not always think to use nurses holding powers to prevent patients leaving the hospital at a time when it was deemed unsafe for them to do so.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory for all staff and compliance levels of 94% were above the provider's target of 80%. Staff were knowledgeable about how it applied to their role. They had access to the hospital Mental Capacity Act policy, and hospital Mental Health Act Law Advisor for additional support.

Staff understood the principles of the Mental Capacity Act and gave examples of how they assessed patients' capacity. Staff documented evidence of their capacity assessments and best interest decisions when patients lacked capacity in relation to their care and treatment.

Nurses completed care plans that considered capacity and best interest decisions such as when they administered medication covertly and made discharge plans.

Older adults units made the Deprivation of Liberty Safeguards applications for patients who lacked capacity. There were delays in the authorisation of applications, which meant that staff had to make urgent applications to ensure they had the legal authority to deprive people of their liberty. At the time of our inspection, we found that one application had expired and one was due to expire and unit staff could not assure us what arrangements were in place.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Specialist eating disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Personality disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Good	Good	Good	Good	Good	Good

Notes

The Care Quality Commission only rate core services; specialist services are not awarded a rating.

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

George Jepson and Katherine Allen units had ligature points and blind spots in rooms and communal areas. (Blind spots are areas where staff cannot see patients at all times. A ligature point is something that patients can use to tie something in order to strangle themselves). The hospital had introduced bi-annual ligature risk assessments and both units had an up to date ligature risk assessment, and risk management plans to mitigate the identified risks. Risk management plans took account of patients' diagnosis, their bedroom location, and their required observation levels. The manager included the environmental hazards on the unit risk register and discussed how to manage the risks with staff at handovers and team meetings.

The units complied with guidance on same sex accommodation because each unit was a single gender unit.

George Jepson and Katherine Allen units scored highly on the patient led assessments of the care environment with Katherine Allen 100% for cleanliness and 88% for condition appearance and maintenance. George Jepson scored 86% for cleanliness and 89% for condition appearance and maintenance.

The units appeared clean and well maintained. Staff kept cleaning records up to date and managers carried out regular environmental risk assessments that ensured the environment was safe for patients and staff. On George Jepson, the unit had new flooring and decoration in rooms and corridors. We saw the manager had completed project proposals that included impact assessments for all work before senior managers approved it. This meant that staff considered patients' safety and put safety measures in place before any work went ahead.

The units had fire procedures in place to keep patients safe. The units had identified fire champions and all staff had fire safety training. Both units had the equipment needed to move patients safely and personal evacuation plans for every patient. Staff knew the procedures in the case of fire; however, neither unit could recollect a recent fire drill to test out their procedures.

Both units had fully equipped clinical rooms with access to the right equipment for physical examinations, emergency drugs and resuscitation equipment that staff checked regularly.

There was good infection prevention and control in place on both units. Staff had access to appropriate handwashing facilities and hand gels. All staff received training in infection prevention and control and demonstrated a good understanding of appropriate measures such as wearing gloves and protective aprons. Each unit had an identified infection prevention and control champion and completed audits to ensure they were compliant with the hospital guidelines.

Both units had a range of specialist equipment such as hoists, wheelchairs, baths, and beds that staff used on a daily basis. When we checked the equipment for evidence of regular maintenance, this was not evident for all the equipment in use. Some equipment did not have visible

stickers and some stickers were out of date. Staff could not provide evidence of when maintenance checks occurred for all equipment and took action during the inspection to address our concerns.

Both units had access to alarms and nurse call systems that staff checked regularly to ensure they were safe to use. We saw evidence that the alarms worked and that staff responded appropriately during our inspection.

Safe staffing

The nursing establishment whole time equivalents on George Jepson unit between 1 May 2017 and 31 July 2017 was:

- Qualified nurse whole time equivalents: 9
- Support worker whole time equivalents: 23
- Number of vacancies of qualified nurse whole time equivalents: 0.3
- Number of vacancies of support worker whole time equivalents: 5
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 43
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 201
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 14

The nursing establishment whole time equivalents on Katherine Allen unit between 1 May 2017 and 31 July 2017 was:

- Qualified nurse whole time equivalents: 9
- Support worker whole time equivalents: 18
- Number of vacancies of qualified nurse whole time equivalents: 2.5
- Number of vacancies of support worker whole time equivalents: 1
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 36
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 57
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 5

Between 01 August 2016 and 31 July 2017, George Jepson unit reported 7% sickness and Katherine Allen reported 2% sickness rate.

There was enough staff on both units that ensured staff spent time with patients. Both units had an ongoing recruitment plan and had recruited to some vacancies at the time of our inspection. The hospital used the NHS England staffing tool to estimate safe staffing levels. Both units needed two qualified nurses on shift during the day and five support workers, at night there was one qualified nurse and two support workers on the units. In addition to staff working shifts, managers worked on the units during the day from Monday to Friday and staff had access to the managers on call system at evenings and weekends. Each unit had an occupational therapist and activities organiser to support patient activities. Managers met daily to review staffing levels and organised staffing to meet the needs of their patients. They used familiar bank and agency staff to fill identified qualified nurse gaps where possible.

Both units ensured that all new or temporary staff received an induction onto the unit. The induction included environmental risks, introduction to the patients, fire procedures, and some hospital policies. The nurse in charge of the unit allocated a member of the team to work with new staff members to complete their orientation and induction to the unit. Both units held a handover at the start of each shift that all staff attended and made aware of concerns and patient risks. We reviewed staffing rotas for the previous three months and saw that both units experienced difficulties providing two qualified nurses during the day. George Jepson relied more on agency staff than Katherine Allen did. When cover for the second nurse was not possible, managers arranged for additional familiar support staff to ensure there was sufficient staff on duty. Staff told us this worked well and was better than using unfamiliar staff with patients who experienced confusion and memory difficulties. On the days of our inspection, we observed that staffing met the safe staffing level and staff were visible throughout the units.

The units shared one consultant psychiatrist who worked four days per week. There was no junior medical staff support. Other psychiatrists in the hospital provided on call cover that ensured medical staff were always available quickly when required. Staff also called emergency services for acute medical conditions.

All staff received and were up to date with their mandatory training. The average mandatory training rate for staff on

George Jepson was 91% and 96% on Katherine Allen unit. This included training on adult and child safeguarding, infection control, risk assessment, fire safety and immediate and basic life support.

Assessing and managing risk to patients and staff

There were no seclusion facilities and both units reported no seclusion or incidents of long term segregation in the past six months. Staff received mandatory restraint training and used restraint on both units. They understood that restraint was a last resort when other techniques failed. George Jepson had the highest number of episodes of restraint with 33 incidents on five different patients between 1 February 2017 and 31 July 2017. Staff did not use prone restraint; this happens when staff restrain patients face down on the floor. Instead, staff used low level restraint such as arm holds to keep patients safe. Staff knew their patients well and planned their care interventions such as distraction and de-escalation techniques to reduce the need for restraint. All patients had positive behavioural support plans with interventions that took account of best practice guidelines.

Staff carried out planned restraint with patients identified at risk of neglect of personal care. Staff clearly documented the least restrictive methods to maintain safety during personal care and reviewed their interventions regularly.

We reviewed 11 care records across both units and saw evidence that staff kept all records up to date. Patients admitted to the unit many years ago did not have clearly documented evidence of their admission. However, staff documented regular reviews of the patients' physical and mental health care. For patients who admitted more recently, staff completed comprehensive assessments that included a physical examination and ongoing monitoring of physical health problems. Nurses used the functional analysis of care environments risk assessment tool and assessed patient's risks at least monthly or more frequently after every incident. Staff observed patients according to the hospital policy that included one to one, 15 minute, 30 minute, and environmental observations depending on their risk assessment. Staff adjusted observation levels according to the risks that included falls, choking and risk of harm to others.

There were appropriate safeguarding systems and processes in place across both units. All contracted staff received training in adult and child safeguarding and training compliance on both units was high. Staff on both units were aware of the hospital safeguarding lead and safeguarding procedures. Both units had safeguarding champions and staff reported safeguarding concerns such as physical assault and allegations of neglect and abuse through the hospital electronic reporting system. Managers received the hospital quarterly safeguarding reports that provided information about themes, trends, and any lessons learned from the safeguarding concerns. Managers shared this information with staff at team meetings.

Both units had made improvements that ensured there were safe arrangements for the storage, dispensing, and recording of medicines. Nurses received mandatory training in medicines management and yearly medicines competency assessments. They all signed a document that confirmed they understood the hospital medicines policy. One member of staff had completed training to be a nurse prescriber however was not fully utilised as there were no clear arrangements for supervision of their role.

Staff stored medicines securely and only authorised staff accessed the room. Staff checked clinic room and fridge temperatures daily and all ensured temperatures were within the recommended range for storing medicines. George Jepson stored the out of hours drugs for the hospital and staff managed this with clear documentation that supported when staff used these drugs. Staff stored controlled drugs securely and carried out checks on a weekly basis. (Medicines that require extra checks and special storage arrangements because of their potential for misuse.) Staff marked liquid medicines with appropriate opening and expiry dates and completed body maps for people who needed creams and patches. This is important to ensure that staff administer these types of medication safely.

The pharmacy staff visited the units regularly and provided support that included quarterly controlled drugs audits and monthly assessment audits that checked for good medicines management practices.

From 1 February to 31 July 2017, George Jepson reported 13 medication errors and Katherine Allen reported nine. Most errors related to documentation and record of administration. Staff carried out daily audits that checked for missing signatures and doses and documented any actions taken. Managers had oversight of medication related errors and took action to reduce the risk of further

errors. They carried out individual staff supervision and ensured nurses responsible completed reflective accounts to support their learning from the incident. If agency nurses made medication errors, managers informed the agency.

Nurses documented codes for missed doses on the patient's medicines card and the electronic record to detail why they used the codes. On George Jepson, we reviewed four administration records for missed doses and found staff explained why this had happened in all four electronic records. On Katherine Allen, we found one patient had three entries of medication not administered on the medicines chart that did not have a corresponding electronic record of why this happened. Staff explained that this could be because agency staff did not have access to the electronic system and should complete a paper record that staff then scan into the system. We checked for any paper records that required scanning and found that all scanning was up to date. We also reviewed the use of as required medicines for one patient and found that staff did not always consistently document administration on both the medicines chart and the electronic record. We brought this to the attention of staff who completed an incident form.

We reviewed eight patient's medicine charts and the corresponding electronic records. Staff documented good practice in all eight records. Nurses completed person centred medicine related care plans and risk management plans that contained the necessary information for staff to administer medicines safely. Both units used a psychotropic monitoring form. Staff documented blood test results and monitoring requirements that they reviewed before prescribing and administering certain medications.

Nurses carried out falls assessments and nutritional screening for all patients on a monthly basis. They referred patients to the practice nurse, hospital physiotherapist, dietician and unit occupational therapist for further advice and support. We saw that patients had individual care plans that reflected their needs. Risk assessments corresponded to the care plans and managed risks such as ensuring that patients wore the correct footwear, and used the correct pressure relieving equipment. We observed this was all in place during our inspection.

Children did not visit on any of the units. Instead, staff arranged use of the hospital visiting room to keep children safe if they visited.

Track record on safety

The hospital reported four serious incidents across both units in the previous 12 months.

George Jepson reported the highest number of serious incidents for older people with mental health problems units with three and Katherine Allen unit reported one. Serious incidents included physical altercations between patients, financial abuse, and injury following a fall.

Reporting incidents and learning from when things go wrong

Staff across both units reported incidents such as self harm, slips trips and falls and violence and aggression. Staff used an electronic system to report incidents, accidents and raise safeguarding alerts within 24 hours of the incident. Unit managers received information about incidents electronically and completed a manager's review within 72 hours. Unit managers and appropriate clinical staff received a daily incident report that included details of all incidents that occurred within the past 24 hours and any action taken. Unit managers attended the daily morning meeting where senior managers and staff from the multidisciplinary teams discussed incidents that occurred in the previous 24 hours. They agreed what action to take and identified any themes or trends across the units. Unit managers included shared learning in their team meetings such as medication errors, incidents of falls, violence and aggression and trends about incidents.

Duty of Candour

All staff received training about their duty of candour at induction and as a yearly update. The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Both units displayed a flow chart that supported staff to follow the duty of candour requirements. Senior managers identified and shared any incidents that met the duty of candour requirements at their daily unit managers meeting. Managers and staff understood the need to be open and honest and apologise to people affected.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Wards for older people with mental health problems

Good

Assessment of needs and planning of care

There were good systems and processes that supported staff to keep patient care plans up to date. Managers regularly reviewed care plans and staff clearly documented review dates for every patient on their visual board in the office.

We reviewed 11 electronic care records and all were up to date. All had evidence of comprehensive assessments and individual care plans that related to the outcome of the assessments. This included assessments of mental and physical health, nutrition and mobility and occupational needs. There were good arrangements for ongoing monitoring of physical health care needs. This was important because patients had ongoing physical health problems such as diabetes and kidney failure as well as mental health problems. Each unit had an identified physical health champions who had oversight of physical health audits and attended the hospital physical health steering group. Nurses completed physical health care plans and reviewed these at least four weekly or more frequently if needed. The unit had a good relationship with staff from the primary medical care service and registered all patients with a local GP. The GP and practice nurse visited both units regularly and carried out annual physical health assessments and ongoing monitoring. They recorded their visits in the patient's electronic record, which meant that all staff involved in the patient's physical care and treatment shared relevant information.

The units demonstrated a person centred approach to care that took account of patients' choices and wishes, their strengths, needs and interventions to support recovery. Two patients on George Jepson were able to understand their care and staff documented that they offered patients a copy. However, most patients on George Jepson had communication difficulties that meant it was difficult for them to be fully involved in their care plans. Staff involved carers where possible and the named nurse met with carers once monthly to go through their relatives care plan. On Katherine Allen staff documented they offered patients a copy of their care plan.

Staff used a combination of paper and electronic records. All information that staff needed to deliver care to patients was kept securely and was available to staff when they needed it. Night staff and administration staff scanned paper records onto the electronic system in a timely way that meant there was no backlog of information.

Best practice in treatment and care

Staff followed the national institute for health and care excellence guidance when they planned and delivered care and treatment. Staff followed the care programme approach framework and reviewed individual care and treatment on a six monthly basis. Katherine Allen was accredited by the Accreditation for Inpatient Mental Health Services and reviewed their service to meet the required standards for reaccreditation. George Jepson was not accredited but had completed initial work to improve the unit environment and experience for patients with dementia. This included redecoration that considered dementia friendly colours and signage and the use of sensory equipment.

Medical staff followed good practice when prescribing medication for older people. Psychology staff completed psychological formulations for all patients and provided psychological assessments if required. They provided individual sessions with patients who had identified psychological needs and provided support to staff such as debriefs following a patient death. Occupational therapy staff offered a range of assessments such as the model of human occupation and pool activity assessment. They completed a comprehensive occupational formulation for every patient that identified their occupational support needs. Staff used this information to provide a range of individually planned and suitable activities such as accessing the community, and physical and recreational activity.

Nurses referred patients to a range of specialists such as dentists, chiropodists, opticians, and audiologists and included the identified care and treatment in patient care plans. Staff supported patients to attend appointments at the local hospital when possible or arranged for unit visits. Nurses referenced national institute for health and care excellence guidance in patient care plans such as the guidance about dementia, depression, management of disturbed behaviour and physical health care.

Staff used outcome measures and rating scales to assess and record patients' progress and outcomes. Psychology staff completed the quality of life assessment and discussed at care programme approach meeting or

multi-disciplinary meetings to support patients' care and treatment. Nurses routinely completed the health of the nation outcome scores (65 plus). Staff used this tool to assess the severity of symptoms for older people. However, staff did not use the results of the assessment in their clinical decision-making, which meant the tool did not support patient care in a meaningful way.

Both units took part in an annual clinical audit programme that included a range of medication and physical health audits that took account of relevant national institute for health and care excellence guidance.

Skilled staff to deliver care

There was a range of mental health professionals. The nurses, support workers, and occupational therapy staff were unit based. The psychiatrist, psychologist, and physiotherapist shared their time with the older people's units. Nurses and support workers received induction and specialist training that supported them in their roles. This included training in physical health and end of life care, prescribing, and dementia awareness. Psychology staff received training in psychological therapies such as cognitive behavioural therapy and used this model to inform patient formulations and support staff. Staff held skills sessions once per month that were in-house training sessions delivered by identified champions. This included appropriate training for the patient group such as palliative care, hydration, and delirium. Both managers of the units had received some management and leadership training and identified further training needs at their appraisal and supervision. This included root cause analysis and project management training to strengthen their skills for carrying out investigations and business planning.

The hospital had a target of 100% compliance for clinical supervision of non-medical staff. The hospital reported from 1 August to 31 July 2017 that both units had not reached the target. Katherine Allen unit reported the lowest rate of supervision as 69% and George Jepson unit with the highest at 73% compliance. During the same period, the hospital reported that 94% of staff on George Jepson unit and 88% of staff on Katherine Allen unit had received an appraisal in the previous 12 months and the consultant psychiatrist had been revalidated.

Both units had good systems and processes in place that supported regular staff supervision and appraisal. Managers explained how they had oversight of appraisal and supervision and what action they had taken to improve compliance. We saw evidence of the electronic information that identified supervision and appraisal compliance. Group supervision and informal supervision occurred but was not always recorded.

Support workers did not have access to regular individual supervision but attended group supervision sessions. All staff had access to regular team meetings that were recorded and accessible for staff. Staff felt well supported and had sufficient information that kept them informed.

Managers addressed poor staff performance promptly and effectively. The hospital's human resource department supported managers when they suspended staff and conducted investigations. Where appropriate, managers issued staff with written warnings, demoted staff, and agreed performance improvement plans. No staff were being performance managed at the time of our inspection.

Multidisciplinary and interagency team work

Both units held weekly multidisciplinary team meetings that included a range of professionals including nurses and support workers. Each unit organised the meetings that meant they reviewed each patient every three to four weeks or sooner if required. Care programme approach meetings occurred at least every six months and involved patients and carers where possible and other professionals such as care coordinators.

Staff planned and recorded the outcome of these meetings on the patient's electronic care record. They documented changes in care plans and risk assessments and communicated these verbally at handover meetings. Handovers between nurses and support staff occurred three times per day when they changed shifts. We observed one afternoon handover on each unit where staff communicated changes to patient care and risks effectively. They used a standard format that ensured staff communicated consistent information and kept handover records for staff to refer to if required.

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

Staff had a good understanding of the Mental Health Act and adherence to the Code of Practice. On Katherine Allen 100% of staff has completed their mandatory training for the Mental Health Act and Code of Practice. On George Jepson 63% of staff had received mandatory training and the remaining staff had booked to update their training in November.

Good

Wards for older people with mental health problems

There were good arrangements in place that ensured all patients had access to an independent generic advocacy service in addition to Independent Mental Health and Independent Mental Capacity Advocates. Advocates attended the unit regularly and supported patients at their care programme approach meetings. The units displayed information about the Mental Health Act and advocacy service and we received positive feedback from the advocacy service about their relationship with both units.

Both units took part in regular audits and completed action plans to ensure they applied the Mental Health Act and Code of Practice correctly. The hospital Mental Health Act Law Advisor supported staff to complete audits that included consent to treatment, patients' rights, and section 17 leave forms. Each unit had an identified Mental Health Act champion and access to an up to date electronic Mental Health Act policy. Staff took actions in response to previous Mental Health Act review visit findings. For example both units worked together to review and update section 17 leave forms fully to ensure they were compliant with the Code of Practice. We reviewed seven section 17 leave forms and all were in order.

Both units were locked which meant that informal patients were not fee to leave without staff assistance. At the time of our inspection, all patients were detained under the Mental Health Act or Deprivation of Liberty Safeguards. Katherine Allen displayed a notice that informed informal patients how they could leave the unit and completed care plans about the use of the locked door and restrictive practices. George Jepson also completed care plans but did not display a similar notice. Staff explained how they would support informal patients to leave the unit if the situation occurred and the manager gave assurances that a notice would be displayed. This was important because sometimes there were delays in authorisations of Deprivation of Liberty Safeguards applications and so patients might not be being treated in the least restrictive way.

Good practice in applying the Mental Capacity Act

On Katherine Allen 100% of staff had completed their mandatory training for the Mental Capacity Act. On George Jepson 80% of staff had received mandatory training and the remaining staff had booked to update their training in November. All staff completed this training every three years.

Staff had a good understanding of the Mental Capacity Act and how this applied to their everyday practice. They accessed support from the hospital Mental Health Act Law advisor and hospital policy when required. Staff assessed patients' capacity to consent to their care and treatment and documented best interest meetings when patients lacked capacity. Staff considered patients' past wishes, advance statements, and involved relatives where possible when making important decisions such as treatment and discharge plans.

Between 1 February 2017 and 31 July 2017, staff made two applications for Deprivation of Liberty Safeguards on each unit. The process for authorisation of the applications was delayed which meant authorisations may expire and staff made urgent applications to ensure they had the legal authorisations in place. However, we found one application had expired and one was about to expire and unit staff were not clear about how those applications had progressed. We raised this with the hospital's Mental Health Act Law advisor who assured us that arrangements were in place.

Both units took part in audits to ensure they applied the Mental Capacity Act correctly with support from the Mental Health Act Law Adviser and unit champions.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

We carried out observations across both units to see how staff behaved when they interacted with patients. This was because many of the patients had communication difficulties and could not tell us about how staff treated them. This included observations at mealtimes, group activities and individual interactions. We observed excellent verbal and non-verbal interactions with patients and carers that were supportive and warm. Staff knew the individual needs of patients in depth and used their knowledge to motivate patients to engage in conversation, activities, and mealtimes. For example, staff knew individual patient food preferences and ensured these were available and prepared to encourage patients to eat. We saw staff ensured one patient had their preferred sandwich filling and another needed red sauce before they

Good

Wards for older people with mental health problems

would eat their meal. We spoke with one patient who told us that the staff were wonderful and most relatives reported staff were very caring, supportive, and treated patients with dignity and respect. Two carers felt some staff on George Jepson could be rude and appeared less caring. The patient led assessment of the care environment scores for privacy on both units was over 85%. The units had identified dignity champions and we saw that staff knocked on patients' bedroom doors before entering.

The involvement of people in the care they receive

Staff on both units attempted to involve patients in the care they received. Many patients could not be fully involved in their care because of their mental health problems and staff always involved relatives and advocates. Staff documented when patients had advance decisions and used a document called respect my wishes with patients, which was an advanced statement about their preferences for their care.

Staff worked collaboratively with patients and relatives to develop and review care plans and documented they offered patients copies of their care plan. Relatives told us they felt very involved in care plans and decision making at care programme approach meetings. All relatives said staff had not provided information about the unit when their relative was admitted, but they now got a lot of information and paperwork. Both units had not had recent admissions but had developed an information guide for patients, family, and friends to give out when people were admitted.

The hospital gained feedback from family and friends of patients with dementia by sending out a survey twice a year. The hospital reported that in October 2016 and March 2017 that 100% of people who responded would recommend the service.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Both units admitted patients from across the country and the majority of patients received NHS funding for their care. As of 1 March 2017 the hospital reported the average bed occupancy over the past 6 months was 87% on George Jepson and 90% on Katherine Allen.

From 1 August 2016 and 31 July Katherine Allen unit reported the number of days from referral to initial assessment as 10 days and from initial assessment to treatment as 36 days.

George Jepson unit reported the number of days from referral to initial assessment as 11 days and from initial assessment to treatment as four days.

The hospital reported the average length of stay for patients on George Jepson unit during this period as 4 years and 2.5 years for Katherine Allen. Although the average length of stay was still significant, we saw that the average length of stay had improved since the last inspection.

The service did not have a clear model or admission to discharge pathway. Katherine Allen described the unit model as an evidence based person centred approach to work with people with complex and challenging needs. George Jepson said they provided tailored care for people who received a diagnosis of dementia but this was not exclusive for admission to the unit. The provider was aware of this and was reviewing the clinical model as part of its emerging strategy.

Both units had patients who had been in the hospital for many years with a mix of organic and functional problems. Katherine Allen had a 50 per cent mix of patients and George Jepson had mostly patients with dementia. Both units tried to create an environment that was homely and dementia friendly to suit the mixed needs of their patients.

Katherine Allen had transferred some patients from another unit in the hospital that had closed in the previous

month. These patients were all older people and the staff from the two units worked together to plan the transfers. All the patients had all settled quickly into their new environment.

Staff said they responded to referrals within 24 hours and set a date for assessment as soon as possible. Staff from the unit organised the assessment at the patient's local environment. On admission, the multi-disciplinary staff completed a 12 week assessment with the patient. Psychology staff completed quality of life assessments and occupational therapists completed a comprehensive report based on their assessments that staff discussed at the care programme approach meeting to plan appropriate on going care and treatment. Staff discussed patients' progress at regular multidisciplinary review meetings. The meeting followed a standard agenda that had recently been updated to include a section about discharge arrangements. Nurses completed a recovery care plan with every patient that included a section called placement review and discharge planning. This was part of the care programme approach process that staff used with every patient.

From 1 January 2016 to 31 October 2017 the service reported six delayed discharges. Katherine Allen had two patients ready for discharge and staff identified that the lack of suitable placement as the main cause of delayed discharges. Staff liaised with home care teams, commissioners, and placement providers to try to resolve the difficulties.

The facilities promote recovery, comfort, dignity and confidentiality

Both units had a full range of rooms and equipment to support patients' comfort and recovery. This included quiet rooms and communal areas, with space for activities and meals. The dining area on both units was pleasant and welcoming although Katherine Allen was too small to accommodate all patients at one sitting because a number of patients used wheelchairs and mobility aids. Patients could choose where they ate their meals, which might include bedrooms or corridors. Staff were present on these occasions and documented this in individual care plans. Not all rooms on George Jepson provided en-suite accommodation, however staff provided commodes and patients used communal bathrooms. Katherine Allen unit was situated on the first floor, which meant patients did not have direct access to a garden area however staff did support patient access to the gardens. On George Jepson, access to the garden had improved. Patients had direct access to a large garden area through an open conservatory. The conservatory was clutter free and comfortably furnished. The manager had based a desk and computer there to work from and welcomed patients to sit with her. Access to the garden was via an electronic swipe card and all patients had an individual assessment to determine if they needed someone with them.

The general atmosphere of both units was calm and relaxed and staff attended quickly to patients who shouted or were distressed. The units appeared well decorated with thought given to dementia friendly colours, comfortable furnishings and signage. Patients could personalise their bedrooms with things they brought from home. However, the bedroom doors compromised patients' confidentiality, dignity, and privacy. The bedroom doors on George Jepson did not have viewing panels, which meant staff had to open doors to check that patients were safe. The bedroom doors on Katherine Allen had viewing panels with material covering the outside for privacy. However, anyone could open or remove the material and the patient had no means of controlling the view from the inside. Staff consulted with patients and relatives about keys for access to bedrooms and lockable space in the bedrooms and completed individual care plans to support the decision.

We did not see that the units had a pay phone for patients to use, however patients could access a ward phone to contact families. Patients could use personal mobile phones and tablets on the wards. Staff supported patients to keep in contact with their families and patients had access to a phone to contact families directly. Both units had drinks and snacks available but this was not freely available to patients. Staff had considered this in their restrictive interventions reduction plan and assessed this as the least restrictive option to keep all patients safe. This was because some patients had risks associated with choking and fluid intake and required supervision from staff. We saw that staff offered and provided drinks and suitable snacks to patients throughout the day during our inspection.

The patient led assessment of the care environment score for food was not available for individual units. This score would inform us of the quality of the food. We saw catering staff delivered trolleys from the main hospital site and the food appeared to be of good quality. Patients chose their

menu ahead of mealtimes with staff support if required. Mealtimes were protected times and appeared relaxed. Staff encouraged relatives to attend and support their loved ones if appropriate. Staff were present with those patients who required supervision during mealtimes. They encouraged patients to be independent where possible and provided adapted cutlery, crockery, and plate warmers to those who required this type of equipment. The occupational therapist was involved at mealtimes and ensured patients had the equipment they needed. Some patients ate in other areas of the unit where we observed staff were not present in the room for up to ten minutes. This meant they did not have immediate help if needed.

Patients accessed a range of individual and group activities throughout the week. Staff invited relatives to take part in activities that happened both on and away from the unit. Activities appeared to be meaningful and appropriate for the needs of the patients. Relatives told us they thought that staff rarely cancelled activities and there seemed to be plenty going on. We observed that units had a range of equipment to support individual and group activities and the units displayed work produced by patients during creative activities.

Meeting the needs of all people who use the service

Each unit was equipped to care for people with disabilities such as mobility problems. Patients had access to assisted bathrooms and toilets with appropriate equipment. Both units had access to a garden area. However, staff supported patients to access the garden via the lift from Katherine Allen because of their location on the first floor.

Both units created a homely and dementia friendly environment to suit the mixed needs of their patients. This was important because approximately half of the patients on Katherine Allen and all but one patient on George Jepson had a diagnosis of dementia. Rooms and doors had pictures to help orientate patients to the environment however signage on bedrooms doors could be improved. The bedroom doors on George Jepson did not have any means of orientating patients to their rooms and the signage on the bedroom doors on Katherine Allen displayed small signage with patient's names only.

Staff had prepared an admission information booklet for patients and relatives that provided information about the unit team and what patients could expect to happen during their admission.

It included information about activities, visiting times, and the complaints process. Both units had a number of well organised information boards and leaflets to inform patients and their carers about carers groups, the Mental Health Act and The Care Quality Commission.

Staff could access signers, interpreters, and information in other forms and languages if required for people with specific communication needs. At the time of or inspection, the unit population consisted of white English speaking older adults. However, staff completed mandatory equality and diversity training and identified equality and diversity champions.

Patients had a choice of food available to them that they could choose in advance. Food was available as "finger food" for patients to manage if required. Staff worked together to ensure that the food met patients' preferences and any dietary or religious needs.

Patients could access spiritual support via the hospital chaplain and specific faith leaders who visited the unit. Staff supported patients to attend religious ceremonies of their choice in the community if needed.

Listening to and learning from concerns and complaints

From 1 August 2016 to 31 July 2017 the hospital reported 35 complaints. Both units for older people reported a low number of complaints with four reported by George Jepson and one reported by Katherine Allen. The hospital upheld three complaints and none were referred to the Ombudsman.

In the same time, the hospital reported 56 compliments. George Jepson received 15 compliments, which was the highest number of compliments received across older person's services. Katherine Allen received four compliments.

Both units informed patients and carers how to complain and displayed information on notice boards and leaflets. Carers told us they knew how to complain and felt confident to raise their concerns with staff but had no reason to raise a complaint. One carer said they raised their complaints informally and another said they were not sure if anything changed because of their complaint.

Staff informed patients and relatives how to complain and displayed a range of information. Managers followed up the complaints and received support from the hospital

complaints lead. Staff told us they received information about complaints and compliments at team meetings and discussed how to make improvements based on feedback from complaints. We saw you said we did feedback displayed on the wards and evidence of team meetings where staff discussed complaints.

Are wards for older people with mental health problems well-led?

Good

Vision and values

The values of The Retreat York are:

- Equality and community
- hope
- care for our environment
- peace
- honesty and integrity
- courage.

Unit staff strongly upheld the values of the organisation and regarded them as central to the way in which they worked. Staff felt that senior management supported the hospital vision and values and felt involved in the hospital values activities. The units displayed information about their vision and values and we saw staff reflected these values in their interactions with patients and carers.

Both unit managers were highly visible and always present on the units. Staff felt supported by their manager and that their leadership had driven required improvements in their systems and processes, the unit environment and culture.

Staff knew who the most senior managers in the organisation were and felt they were very visible and approachable. Senior managers had visited both units to attend team meetings and spent time working on the unit. Staff felt this helped managers to understand the issues of the service and listen to their concerns.

Good governance

The governance arrangements across both units were good. Managers had oversight of staff performance and took action to ensure that staff completed required training, appraisal, and supervision. Both units participated in a comprehensive audit programme with specific identified leads that ensured staff acted on outcomes of audits.

Managers ensured that the unit staffing levels were sufficient to maintain safe patient care and that new staff were suitably inducted and managed. Both units followed hospital policies and procedures and reported safeguarding concerns, incidents, and complaints. Managers investigated areas of concern and shared findings and learning with staff.

The units had individual risk registers that reflected appropriate risks and risk management plans for the service. The manager on George Jepson had clearly documented business proposals and impact assessments for work that might affect patient care. This was an improvement from our last inspection in February 2017. At that inspection we found that work on the unit had affected patients' safe care and treatment. The manager assured us they would use this process for any future changes affecting patients such as changing bedrooms or completing works.

Leadership, morale and staff engagement

Staff morale was improving following recent changes in senior managers and leadership arrangements on the older people's units. Staff felt they would raise concerns without fear of victimisation and that managers listened to their concerns. They had concerns about the future of the units because of the lower than usual occupancy rates on George Jepson and reduction in referrals to the service. Following our inspection in February 2017 a number of staff had left the unit and ongoing recruitment had not filled all the vacancies. This affected staff morale because staff were concerned about staff recruitment, retention, and their reliance on agency staff to maintain safe staffing levels. However most staff felt well supported and enjoyed their jobs.

Managers and staff said they felt sufficiently informed about proposals for developments with the service and were aware of "work stream" proposals from the senior management team. However, staff had not been involved in the development work and were unclear about details of the 'work streams'. At unit level, staff felt clear about their roles and the expectations of the unit managers and felt able to provide good quality, and safe patient care.

Good

Wards for older people with mental health problems

Commitment to quality improvement and innovation

Katherine Allen unit was accredited with the Royal College of Psychiatrists in April 2014 and was validated until January 2018. A unit is accredited when services are able to demonstrate that they meet a certain standard of best practice in a given area. The unit had a peer review in July 2017 and submitted evidence in September 2017 to the accreditation panel to support their reaccreditation. George Jepson had completed a lot of work to improve systems and processes and the unit environment. The improvements were based on the accreditation standards and good practice in dementia care.

Managers identified that the units lacked a clear model and pathways for care, which affected patients' length of stay and discharge planning. The provider was aware of this and was reviewing the clinical model as part of its emerging strategy. Both units were starting to work together to share ideas and learning to make improvements in the service for older people.

Provider level Governance

Vision, values and strategy

The hospital's mission, visions and values were;

- Mission – Why do we exist? In a beautiful setting, we promote and support the wellbeing of people affected by mental ill-health, working with them to nurture their unique potential so that they can have a life worth living.
- Vision – Our future as we see it? To deliver high quality specialist mental health services through compassion, collaboration and community.
- Values – Rooted in the Quaker values of Hope, Equality and Community, Courage, Care for our Environment, Peace, Honesty, and Integrity. We aim to implement these values in every aspect of our work.

Staff at The Retreat York cited the values as a strength of the provider. The Retreat York held an annual values week where patients and staff completed activities that reflected the values. Staff in the organisation were able to demonstrate the values in their discussions and behaviours, but many unit level and support services staff were unclear about the provider's vision and strategy.

The provider had recently completed a quality improvement programme that responded to issues identified in the previous two Care Quality Commission inspection reports and reviews by the local authority safeguarding team and commissioners. The provider was in the process of finalising the actions and direction of the organisation and had identified an emerging strategy that aligned with the organisation's six key strategic objectives:

- Develop as a centre of excellence in compassionate care (for inpatient and outpatient services).
- Become agile within the changing the mental health landscape, developing appropriate and effective partnerships and collaborations.
- Ensure our environment is fit for modern purposes and that it can be used flexibly and smartly
- Improve the delivery of care and the responsiveness of services through the effectiveness and efficiency of our systems and processes.
- Improve the recruitment and retention of staff.
- Enable the people who use our services to find meaningful engagement within their communities.

The provider had held an away day in April 2017 and invited all middle managers, senior managers and trustee directors from across the organisation. The aim of the workshop was to develop a mission statement and build detail into the high level strategy that was shared with the same staff at the leadership forum in March. They hoped to capture enough information, insight, ideas and thoughts to be able to create a detailed strategic plan that identified improvement work streams for the next three to five years. The provider had considered the commissioners needs and was modifying services to ensure they reflected the changes required.

At the time of inspection, the Retreat York had employed a programme manager until March 2018 to oversee completion of the 32 work streams identified at the away day. These had been consolidated into five projects.

- Project 1 - Service Development
- project 2 - Business Development
- project 3 - Estates and Facilities
- project 4 - Internal Systems
- project 5 - Employer of Choice.

Each project had an accountable director and middle manager lead. The programme manager had identified dependencies on other work streams, assigned target completion dates and recorded risks to delivery. The projects reflected the organisation's current financial position and hoped to improve revenue. The finance

department worked with the project leads to provide costings. The leadership team monitored progress at leadership team meetings and at trustee board member meetings.

Although the chief executive updated staff of these changes via an internal newsletter, leadership forum meetings and individual unit team meetings, we found that staff were not aware of the work being completed. With the exception of the allied health professionals, staff we spoke with that were lower than middle management were not currently involved in work streams. The board assurance framework had identified the risks associated with staff involvement and had communicated the emerging strategy to the middle manager tier and the employee management forum however the message had not spread throughout the organisation. The employee management forum had been recently established as part of the emerging strategy and had met in September 2017. We viewed meeting minutes and identified that on this occasion, of the seven staff present, four were team lead/ middle manager level or above. This may inhibit open and frank discussion and feedback from the staff.

Good governance

The senior leadership team were accountable for the running of the organisation and had oversight of governance and quality issues through sub committees. The organisation had four levels within their governance assurance structure:

- Level 1: Board of trustee directors
- Level 2: Governance committee, leadership team, audit committee, finance and resources committee and the remuneration committee
- Level 3: Groups for clinical governance, research, health & safety, fire, environment and non-clinical risk, policy development & ratification, patient experience, business development and contracts, leadership forum, employee management forum and the unit managers
- Level 4: Groups for clinical audit, mental health law scrutiny, information governance and information technology, clinical therapeutics, infection control, training, safeguarding, accreditation, clinical records and care programme approach, green (environment), involvement forum, friends, family and carers nutrition carers support and spirituality.

The governance structure allowed for information to flow from units to board and board to units.

The senior leadership team included the chief executive, medical director and three directors who were responsible for strategic leadership. The board of trustee director's role was to provide advice and challenge the leadership team. There were eight trustees directors in post, including a clerk. One of the trustee directors had stepped down from their role to act as an interim financial director of The Retreat York until the post could be filled. We observed an open and honest relationship between the board of trustees and the leadership team. We viewed meeting minutes where the senior leadership presented updates and saw that the board monitored progress. However we found the format of the minutes did not allow for easy identification of actions to follow up because records were written in a narrative format.

Average mandatory training rates across the organisation exceeded the provider's individual compliance rate however at unit level there were courses that had not met the required standard. Although training sessions were arranged for 'pronouncing expected death of a patient' and 'prevention and management of violence and aggression' training other courses did not meet the internal mandatory training figures at unit level. Each unit provided specialised training as part of the induction process.

The organisation had good systems and processes in place that supported regular staff appraisals. Managers explained how they had oversight of appraisals and what actions they had taken to improve compliance. We saw evidence of the electronic information that identified appraisal compliance. Appraisals were being reviewed to reflect the emerging strategy. The Retreat York had identified that supervision was not regularly occurring in the organisation, the lowest rates being on Kemp unit and Naomi unit at 30% and 36% respectively. George Jepson had the highest rates at 73% however this was below the provider target of 100%. The provider had set compliance targets for each unit to achieve 80% by October, 90% by November and 100% by December 2017. Group supervision and informal supervision occurred but was not always recorded.

The provider met staffing levels on Naomi and Acorn units; however we saw gaps in rotas on the other units. On older adults units managers arranged for additional familiar support staff to ensure there was sufficient staff on duty whereas on Kemp there was high agency usage and the unit manager and deputy manager were supernumerary and would cover shifts. Agency staff used on Kemp were

familiar with the unit and the patients, where possible. The Retreat York had also introduced a supernumerary night site coordinator role four days a week to monitor night staffing levels and were recruiting another. On a daily basis and staffing was discussed Monday to Friday at unit manager meetings.

Unit managers and organisational leads were engaging in clinical audit and this was monitored by the organisation's audit lead. The audit programme included 83 audits categorised under medication, national institute for health and care excellence guidance, clinical practice, the Mental Health Act, information governance as well as patient and staff experience surveys. Action plan leads and monitoring governance sub groups were detailed on the clinical audit programme and we saw that audit action rated high or very high fed on the appropriate risk register. The provider monitored quality and systems and identified where action should be taken. Although we saw no issue with infection control on the units we reviewed the infection control policies and procedures as part of the inspection. We saw that external guidance adopted by the organisation relating to infectious outbreaks was dated 2012 and 2015; the organisation had not had an outbreak since November 2015. The provider informed us that the infection control policy was due to be updated in review in November 2017. This is to be undertaken by the infection control lead and discussed by the infection control group. The policy development and ratification group would then sign off the final version.

All staff knew how to report incidents and mechanisms were in place to update staff across the organisation; However, we did not see a formal process for ensuring the learning from incidents was embedded and reviewed. Incidents were discussed at handovers and team meetings. Unit managers and appropriate clinical staff received a daily incident report that included details of all incidents that occurred within the past 24 hours and any action taken. Unit managers attended the daily morning meeting where senior managers and staff from the multidisciplinary teams discussed incidents that occurred in the previous 24 hours. The quarterly clinical governance report reviewed incidents in the organisation. It had defined categories, recorded actions taken and monitored trends. We reviewed one governance report that identified that incident report forms were not being updated by the assigned reviewer in line with the organisation's policy and saw that this was raised as an issue for further action in the clinical governance report.

Staff and patients were clear on the complaints process. We reviewed 14 complaints and saw that they contained appropriate information that recorded the basic facts and findings, that patients, families and carers were engaged where appropriate and that reviews and investigation were completed. However there was a lack of clarity as to how lessons learnt were checked to see if they had been embedded in the service.

The provider told us they had a restrictive intervention reduction programme that had allowed for the development of an organisation action plan, unit action plans and individual patient plans. We saw that Acorn unit had completed the provider's action plan template in September 2017 but other documents relating to positive and proactive care work were undated (Katherine Allen) or last updated in 2016, for example minutes from the organisation's positive and proactive care group were dated February 2016. We did not see an ongoing review of restrictive practices.

We saw that that monthly financial accounts were monitored, reviewed and disseminated throughout the organisation. The Board and the finance and resource committee monitored the financial position. The organisation had recently devolved budget management and accountability to the individual units to enable greater understanding of unit costs and influence expenditure. The 2016 auditors report confirmed compliance with required financial processes however we saw a lack of activity in strategic financial forecasting. The organisation was aware of this and had appointed a new finance director; this appointment was going through human resources processes at the time of inspection. The provider had already employed an additional management accountant so that finance activity related to the work streams could be managed.

We reviewed seven safeguarding concerns for the organisation including recently closed and raised. We found there to be thorough investigations, methodical reviews and clear documentation. We spoke with the safeguarding lead and saw that safety planning meetings were held and risk management plans and observation plans for patients completed. The social work team

contacted the unit managers providing an overview of implemented safety plans. There was discussion at handovers and senior leadership team meetings. The safeguarding team identified trends with timelines and raised concerns appropriately with the local authority, with whom they had a close working relationship. Carers and patients views were sought and documented and records identified incident reference numbers from the incident reporting system. The service escalated matters to the police and informed the Care Quality Commission and commissioners when appropriate. Safeguarding records also referred to the duty of candour responsibilities and learning from safeguarding incidents was monitored by the governance committee.

We reviewed the files of 12 patients detained under the Mental Health Act and found documentation to be well structured, organised and complete. The organisation's Mental Health Act lead provided a monitoring report for the governance committee each quarter that detailed current detentions and Deprivation of Liberty Safeguards authorisations, use of holding powers, community, metal health tribunals, patient transfers and discharge from detentions. Where holding powers were used the provider asked that unit managers monitored the duration of which patients were held, the attendance time of doctors and the proportion of applications for detention following the use of the holding powers. Older adults units made Deprivation of Liberty Safeguards applications for patients who lacked capacity. There were delays in the authorisation of applications, which meant that staff had to make urgent applications to ensure they had the legal authority to deprive people of their liberty.

The provider was aware of its performance in its service areas through use of key performance indicators and productivity metrics that were reported through the governance structures. Unit managers collated standardised reports that were reviewed by the senior leaders; unit managers met with the senior leadership team every fortnight to review the organisation's quality improvement plan. Performance measures were in an accessible format and were used at different levels within the provider. The Retreat York communicated performance data via the leadership forum, staff notice board and email bulletins. The organisation was aware that they had a lot of management information and hoped that the implementation of the new intranet would help to further organise and communicate this information.

The provider has good working arrangements with commissioners, local authorities and other partners and third party organisations. We received positive feedback from external stakeholders including advocacy, commissioners and local authorities. We saw that the senior leadership team held regular meetings and worked collaboratively with external organisations.

Each unit had a risk register and unit managers were able to input items on the risk register. The risks were rated in relation to their severity in line with the National Patient Safety Agency's risk scoring matrix. The provider had recently created individual risk registers that fed into the corporate register. High or very high risks included the financial position, policies, clinical audit, business continuity plan; agency staffing and we saw individual items for example, relating to the environment on George Jepson unit and supervision levels on Kemp. The risk registers identified control type and details, gaps in controls and review dates, however there was no date added recorded; this could mean that risks were being overlooked and there wasn't oversight of the length of time a risk had been on the register.

The organisation had employed a consultant to complete a fire assessment of the premises who was now employed as the acting facilities manager. Since being in post the service had passed a fire safety inspection with the North Yorkshire Fire Service; doors were fully complaint with guidance and the building was compartmented to restrict the spread of fire. We reviewed documentation relating to the environment such as fire, electrical and gas certificates and found them to be in date and well ordered. Units had fire procedures in place to keep patients safe. The units had identified fire champions and fire safety training was part of the mandatory training suite. Units had the equipment needed to move patients safely and personal evacuation plans for every patient. Staff knew the procedures in the case of fire.

We undertook a review of the implementation of the Workforce Race Equality Standard. The Workforce Race Equality Standard is a mandatory requirement for organisations that receive at least £200k of their aggregated annual income from NHS-funded care. Organisations are to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic backgrounds have equal access to career opportunities, receive fair treatment in the

workplace and to improve black and minority ethnic board representation. We reviewed a completed reporting template from April 2017; however, details relating to the board lead for the Workforce Race Equality Standard, commissioners (recorded as having received the report), and action plan in response and board sign off were blank. As of June 2017 the service had not completed a full audit of personnel data to complete the evaluation. Statistics reflected the City of York ethnicity demographics. We saw an Equality Delivery System two compliance document that was completed in 2015, which the provider acknowledged, was due for review, however we saw no review date on the document. The provider was reviewing the Equality Delivery System two action plan and the task of updating the compliance document had been allocated to the new involvement lead who was due to start early December 2017.

Leadership and culture

There had been a number of changes to the senior leadership team since the previous two inspections. The organisation had recruited a new full time medical director, an interim director of operations, in post until July 2018, and a director of development that had previously managed the outpatient services of the Retreat York. The service had also recruited a finance director and interim human resources director; however neither was in post during the inspection. The new leadership team were knowledgeable, experienced and had the skills to develop the organisation. The change in leadership team had been communicated to staff, however staff were anxious and hoped for a period of stability.

The provider conducted quarterly friends and family tests. There had been an increase in staff responses that would not recommend the organisation to work in and would not recommend the organisation for treatment. The service had communicated these results out to staff and an action plan was seen that was hoping to address these issues. Staff still referred to the damage caused to morale and culture by the previous leadership team but there was a lot of respect and hope for the new leadership team. The leadership team had implemented stronger processes and controls and staff felt supported by their immediate line managers.

The organisation relied on cascading of information through the middle management tier leadership forum and email bulletins however recognised that information was not always getting to staff. In response to this the provider intended to create a standardised meeting template with recorded minutes. Senior leaders attended team meetings and the organisation had a planned date to roll out a new intranet system. The senior leadership team had attempted to improve communication with staff via different methods such as a 'rumour wall' to access staff who wanted to remain anonymous and informal sessions with the senior leadership, both during the day and evening to access more staff, in the staff canteen. However uptake of the sessions was poor and the rumour wall was unmoderated which meant that comments became personal and inappropriate. The senior leadership had an open door policy and we saw that some staff chose to raise concerns directly with the senior leadership team.

Staff concerns related to staffing, pay inequality and the financial position of the organisation. Staff felt that a pay review across the organisation would improve the recruitment and retention of staff and increased pay would result in less reliance on agency staffing. The leadership team offered reassurance and these risks were identified on the risk registers and business assurance framework; actions to address these issues were identified in the emerging strategy. During the inspection the leadership team informed us that they were in the process of rolling out the 'living wage' for non-clinical staff. The Retreat York also intended to implement a salary review for other staff to be completed by the new interim director of human resources once appointed. The provider told us that they were hoping to introduce a performance management system to address any poor staff performance and we saw that issues identified with agency staff were addressed immediately.

We reviewed 26 personnel files including doctors, nurses, multidisciplinary team members, trustees and directors. A provider is required to complete checks on its directors to ensure they meet the requirements of the fit and proper person test. All files contained appropriate information regarding recruitment requirements; references, disclosure and barring service checks. Individual terms and conditions were in place, using a standard Retreat York format that gave starting dates, remuneration, and clarification on expected conduct and supporting human resources policies. More recent files contained a checklist that had to be signed and countersigned, confirming receipt of essential information, receipt of disclosure and barring service. However we did not detect any reference to conflict

of interest, which would have been particularly appropriate in the director files. We saw that three doctors appointed before 2017 had registration details present but no obvious evidence of renewal in the files. However the Retreat York had submitted data that showed that all doctors registration details were valid and in date.

The organisation had a duty of candour policy that detailed the organisational approach. Unit managers discussed incidents that met the duty of candour threshold at unit manager meetings and a communication log was kept and monitored by the governance department that reported to the governance committee. All staff received duty of candour training on induction and we saw information on staff notice boards and in safeguarding records relating to staff responsibilities. We saw that the organisation had informed patients and families of any incidents that met the threshold. The leaders of the organisation encouraged openness and honesty. Staff knew how to use the whistle-blowing process and staff felt able to raise concerns without fear of victimisation. The organisation had a Freedom to Speak up Champion however this was the current human resources manager which may act as a barrier for some staff to be open and honest. Since October 2016 three staff had approached the Freedom to Speak up Champion.

Engagement with the public and with people who use services

The provider had an involvement lead post who worked with patients and families to ensure patients were involved in their own care, service development and regional and national agendas. There was no one in post during the inspection however a new lead was due to start in December 2017. The previous involvement lead worked closely with the leadership team and safeguarding team to gather feedback and improve communication with patients, families and carers. Unit staff described patients as a priority and spoke highly of the involvement office whose role was to make sure that patients' voices were heard. The hospital also gained feedback from patients, family and friends of patients by sending out surveys.

Many patients on older adult units could not be fully involved in their care because of their mental health problems however staff always involved relatives and advocates. Older adult units held carers groups and carers and families were able to feedback on the service to staff.

Patients on the other units told us that they worked collaboratively with staff and were involved in their care planning. Patients were seen to be involved in the recruitment of staff and values week.

The governance structure included an involvement forum (quarterly), friend's family and carers forum (quarterly), one to ones with patients, workshops for projects and carer support groups. Issues raised could be escalated to the leadership team as they attended the involvement forum and a member of the leadership team line managed the involvement lead.

We queried how the organisation met the Accessible Information Standard. The Accessible Information Standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given. The Retreat York explained that they had provisions in place for patients; each assessed on an individual basis, however they did not reference accessible information provision for carers and families. The organisation confirmed that compliance with the Accessible Information Standard was the remit of the new involvement lead.

Quality improvement, innovation and sustainability

The Retreat York had identified its emerging strategy based on the 'Hedgehog concept' methodology. This approach identifies what people are passionate about, what the organisation does better than anyone else and determines where they are good at generating revenue. Following this the organisation employed a programme manager to oversee its improvement process. During the inspection we raised concerns over the project management responsibilities that middle managers would be responsible for on top of their usual responsibilities. The programme manager had identified this as a risk to the delivery of the program and the organisation were looking to recruit a project manager to offer support. Another risk identified to the success of the programme was delays caused by late or incomplete actions from other work streams. For example, we queried when the new strategy would be finalised with the middle management team, senior leadership team and trustees of the board and were told different dates.

Although the provider was under financial pressures, the board of trustees had allocated a budget for improvements

to the organisation to complete the work stream activity. When completed the organisation expected that the financial situation would improve as the services provided would better meet the needs of the patients and commissioners. Currently the organisation was using reserve funds so that the quality of patient care was not affected.

The provider was unable to participate actively in national clinical audits as they did not have the minimum number sample of patients required to participate.

Naomi, Katherine Allen and Acorn units had participated and received approval in national quality improvement programmes. This accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided. Naomi was accredited by the Royal College of PsychiatristsQuality Network for Eating Disorder Adult Inpatient Standards. Katherine Allen unit was accredited by the Royal College of Psychiatrists and Acorn unit was accredited by The Community of Communities. On Naomi unit the consultant psychiatrist and unit manager were writing a paper for the Royal College of Psychiatristson eating disorders and veganism and George Jepson had improved systems, processes and the unit environment based on the accreditation standards and good practice in dementia care. On Kemp unit, as a result of the lack of evidence based guidance on dissociative identity disorder, the service was developing their own guidance including developing a business plan for trauma informed care. The Pottergate Centre for Dissociation and Trauma centre had recently carried out an assessment of the work carried out on Kemp unit and the results were positive.

The organisation had recently implemented a new change management policy and process so that all staff followed a standard process for changes to anything within the organisation, for example, a system, process, structure, staffing or environment. The approach ensured senior management oversight and review; changes were discussed at leadership team meetings and could be escalated to the board of trustees. Staff used a standardised template to plan any changes and reviewed risks needed approval to proceed. Any changes that affected patients and carers were to be communicated to them. The process also reviewed the change after implementation. We saw an example of this in practice when the flooring work had been completed on the George Jepson unit.

Specialist eating disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are specialist eating disorder services safe?

Safe and clean environment

Naomi unit is located on the first floor of the main building. The unit had a stair lift to allow access from the ground floor. Patients and staff had key fob to access the unit. The existing layout did not allow staff to observe all parts of unit. The unit had long corridors with corners and turns. Staff monitored the risks with regard to ligature points and blind spots within the unit and completed ligature assessments. A ligature point is something, which people can use to tie something to in order to strangle themselves. Individual risk assessments were completed for all patients and each room was individually risk assessed. When patients were admitted they were admitted to ligature free rooms on the unit. Risks were also mitigated by mirrors and cameras in isolated exit areas and blind spots on the corridors. Allocated staff conducted environmental observations every 15 minutes and signed the environmental risks recording sheet to confirm when completed. We observed one staff handover where risks to all patients were fully discussed.

We observed the unit to be clean and well maintained and patients confirmed the cleanliness of the unit, however, one patient felt that the decor, furnishings and fittings could have been improved. We saw good infection control measures in place. Staff used gloves and aprons to protect themselves and had access to appropriate equipment. Staff on the unit adhered to infection control principles in relation to dress code. Cleaning records were kept up to date and included all of the unit areas. A recent patient led assessment of the care environment found some issues relating to cleanliness of fixtures such as lights and soap dispensers and some stains on walls and bathrooms; however assessors were confident that the environment supported good care. Naomi unit scored 82% for cleanliness and 84% for condition appearance and maintenance.

The unit was female only and had no seclusion facilities. There was an alarm system in place and staff carried personal pagers. We observed nurses getting alarms at the start of shifts and saw alarms to be in full working order. Nurse call systems were available in patient bedrooms, corridors and in communal areas of the unit.

There was a well-equipped, clean and organised treatment room with accessible resuscitation equipment; emergency drugs were checked regularly. Room and fridge temperatures were recorded daily and were within the recommended ranges. We checked the equipment and medicine stored for emergencies and found all items were fit for use. Daily checks had been completed for the defibrillator on Naomi unit. The unit shared an electrocardiogram machine with one of the older adults units. The clinic room had an examination couch. Hand washing facilities and notices were present through the building and alcohol gel dispensers were placed in doorways, the clinic room and the dining room. Medicines were stored securely and access was restricted to authorised staff.

Safe staffing

The nursing establishment whole time equivalents on Naomi unit between 1 May 2017 and 31 July 2017 was:

- Qualified nurse whole time equivalents: 11
- Support worker whole time equivalents: 14.5
- Number of vacancies of qualified nurse whole time equivalents: 2
- Number of vacancies of support worker whole time equivalents: 2
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 19

- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 8
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 6

Daytime staffing was two qualified nurses and three support workers, night-time staff was one qualified nurse and two support workers. There were also additional staff disciplines on the unit such as psychologists and occupational therapists for individual and group work with patients. We saw that staff on the rotas matched those on the shifts and there were no gaps or staffing issues in the rotas we reviewed. Rotas were produced four weeks in advance and incorporated staff preferences and allowed for family commitments.

Patients told us that there were enough staff on the unit and that leave and therapy sessions were not cancelled. One patient described one occasion where a group was cancelled with no explanation or advance notice, however commented that leave was always available. Another patient described when a member of staff had missed their break to keep them safe on the unit. There were enough staff to safely carry out physical interventions when required.

The total number of substantive staff between 1 August 2016 and 31 July 2017 was 28; 12 staff left during this period. Excluding seconded staff, the unit had 12% vacancies between 1 August 2016 and 31 July 2017 and 8.2% sickness, which was higher than the overall inpatient unit average sickness figure of 4.9%. During the inspection the unit manager informed us that they had recruited to one of the vacant posts and had multiple applicants for the other qualified nurse vacancy on the unit.

Patients had regular one to one time with their named nurse and support workers; one patient commented that they had more time with staff at The Retreat York than they had in other hospitals they had been admitted to. Patients also told us that regularly saw the unit consultant psychiatrist and appreciated the consistency of having one consultant whom they saw regularly. Staff were visible in communal areas of the unit and a qualified nurse was on the unit each shift.

Staff told us that they rarely used agency staff and when they did it was mainly to cover patient observations. When bank and agency staff were used, they were familiar with the unit and patients. The unit manager confirmed that they were able to adjust staffing levels daily to take account of the skill mix. Managers attended a daily managers meeting where staffing issues were discussed and responded to. We also saw that Naomi unit displayed their staffing levels on the safer staffing boards.

The hospital used the NHS England staffing tool to estimate safe staffing levels. Senior staff worked on the units during the day on weekdays and staff had access to the hospital on call system on evenings and weekends. The Retreat York had also introduced a supernumerary night site coordinator role four days a week to monitor night staffing levels and were recruiting another. On a daily basis and staffing was discussed Monday to Friday at unit manager meetings.

For medical cover out of hours, staff on the unit would contact the out of hours GP service or call 999 in the event of an emergency. The organisation's consultant psychiatrist also provided support via the out of hours rota. There were no junior doctors to support the psychiatrists.

The Naomi unit followed the mandatory training as set by the provider. Average training compliance was 86% on 31 July 2017, which is above the provider target of 80%.

However the following courses were below the target:

- Fire safety: 68%
- medication competency: 64%
- pronouncing expected death of a patient: 45%

Fire safety training was below the target at the last 2016 comprehensive inspection and remains an issue at this inspection. Fire safety is particularly relevant for Naomi unit as evacuation would be from the first floor of the building.

Medication competency training was 64%. During the 2016 inspection we identified that the provider did not ensure that staff responsible for the management and administration of medication were suitably trained, competent and reviewed. During the 2016 inspection staff were not following policies and procedures about managing medicines. On this inspection training levels on Naomi unit were lower than the internal target.

Pronouncing expected death of a patient was a new mandatory course for all nurses. The provider had booked all staff into sessions over a two month period.

Assessing and managing risk to patients and staff

There were no incidents of restraint reported from 1 February 2016 and 31 July 2017. Staff described using de-escalation techniques such as mindfulness and grounding and using low level arm holds if de-escalation failed. Patients confirmed that this was the case. No rapid tranquilisation or prone restraint, (when the patient is restrained face down), was reported as used during the same period. The Retreat York reported no incidents of seclusion or long term segregation between 1 February 2016 and 31 July 2017.

All patients were risk assessed on admission and every three months after, or earlier, if an incident occurred. Staff could describe how the unit assessed and managed risks. They described the observation policy, environmental and ligature risks assessments and we saw that patients had crisis plans in place, for example, what to do when a patient may go missing. Patients told us that risk assessments were completed collaboratively. In the event that a patient was at risk they would hand in their key fob to minimise risk off the unit. We observed one handover where risks were discussed. Risk was also discussed in multidisciplinary team meetings, formulation meetings and handovers.

All the patients on the unit were informal during the inspection; they had key fob access to enter and leave the unit as they wished and we found no blanket restrictions on the unit.

Staff were trained in safeguarding and knew how and when to make a safeguarding alert. Staff contacted the social work team who lead on safeguarding in the organisation. Safeguarding was visible across the service. Internally, the safeguarding lead for the organisation attended the unit managers' meetings once a week to feedback any learning and externally there were good links with the local authority and commissioners. Safeguarding concerns fed into the incident reporting system. As of 31 July 2017, the compliance rate for safeguarding adults general awareness was 96% and child protection level one basic awareness was 94%. Child protection core level three was below that training target rate at 64% in July but had increased to 93% by the inspection. Safeguarding was also addressed during staff supervision sessions.

Medicines were supplied under a service level agreement from an external pharmacy. Medicines were stored securely and access was restricted to authorised staff. Two dedicated pharmacists and a technician service were provided on all units. Medicines reconciliation was completed for all new admissions by the technician led service. Unit based staff described a good working relationship with the pharmacy team.

The Retreat York had a children's visiting area available in the shared area in the main building which could be used should relatives bring children to visit patients.

Track record on safety

There had been four serious incidents requiring investigation as reported by the provider between 1 August 2016 and 31 July 2017. These included the staff management of patient's need, one patient medication overdose, one patient absconding from care and one inappropriate staff behaviour towards a patient.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report, how to report them and were able to tell us the process. Incident reporting was included in the unit induction. Agency staff were unable to access the incident reporting system; they would rely on substantive staff members to log incidents on their behalf. Unit managers reviewed the incidents for their unit, made recommendations and returned the feedback to the person that raised the incident. The senior leadership team also reviewed incidents. The unit worked as a modified therapeutic community and patients and staff discussed incidents and solved problems as a group at daily meetings. Patients and staff also held joint emergency meetings in evenings following an incident. One patient was unhappy that they had to stop what they were doing to attend these meetings. Trends were reported quarterly to the board of trustees via the clinical governance report. We saw that changes were made in response to incidents. For example, the organisation had introduced a change management process that required review by the senior leadership team and board of trustees before changes could be implemented on the units. We saw changes to medicines management procedures to reduce the risk of medicines errors and each unit had identified staff to champion key issues such as safeguarding and infection control.

Duty of Candour

Incident reporting forms incorporated a duty of candour section and staff were aware of the provider's policy and their responsibilities within this requirement. The duty of

candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The organisation had a duty of candour policy that detailed the organisational approach. Unit managers discussed incidents that met duty of candour as a standing agenda item and a communication log was kept and monitored by the governance department. This was also reported on in quarterly governance reports. Lessons learnt were reported back to staff via email bulletins. The organisation were in the process of implementing a new intranet system that they hoped would help to improve communication.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

We viewed six patient care and treatment records that were stored on the electronic record system. All of the care plans had been reviewed in the month prior to the inspection. Naomi unit received referrals nationally and had weekly referrals discussions and clearly defined inclusion, and exclusion criteria. Patients received a physical assessment on admission and there was evidence of ongoing physical health monitoring. One patient said that they had additional physical health needs that had been identified and resolved since their admission. The organisation had previously pooled administrative staff that had resulted in delays to scanning of test results. However The Retreat York had since acknowledged this as an issue and had two dedicated administrative staff per two units to provide support. Administrative staff attended the unit and collected items for scanning. Paper copies of physical health results such as blood results were kept in a separate paper file but we saw entries made on the electronic record system informing staff of the results.

Records were holistic and identified the patients' needs and views but were not always written in the patient's voice. All patients described how staff respected their opinions and how care plans were written collaboratively. Patients had crisis plans in place that addressed how to support patients at risk. Care plans were recovery orientated and followed the pathway and therapeutic approach of the unit.

Best practice in treatment and care

Naomi unit used a cognitive behavioural therapy based model, called 'pathways to recovery' based on the national institute for health and care excellence guidelines for the treatment of eating disorders, mood and anxiety disorders (Eating disorders in over 8s: management - CG9). Staff also referred to royal college of physician guidance (CR189) for the 'management of really sick patients with anorexia nervosa'. Staff described trauma focused work where nurses worked closely with therapists providing food related exposure sessions.

Detailed care plans were in place for medicines which covered side effects, how patients liked to take their medicines and what monitoring was required. Risk assessments were in place if necessary. Five patients self-medicated on the unit and assessment forms had been completed, reviews took place to ensure patients were taking their medicines as prescribed, and medicines were stored securely in patient's rooms. Self-medicating was regularly discussed as part of multidisciplinary team meetings. Home leave was facilitated with the pharmacy to ensure adequate supplies of medicines were available. Missed doses were reviewed through a daily audit and codes were appropriately recorded with supplementary entries made on the electronic system.

Patients could access treatment for their physical health needs; a GP and physical health nurse visited the unit regularly. The Retreat York also had a physiotherapist trained in acupuncture. Staff described physical health training offered to staff on the units including support workers. There were no nurse prescribers on the unit. The unit had good working relationships with the gastroenterology department at the local acute hospital.

Staff were present at mealtimes and supported patients to eat and drink. This meant that risks were monitored and staff were aware of patient's food and fluid intake. Patients spoke positively of the support given. Psychosocial activities included shop and cook, life skills, foundation skills group, advanced and core cognitive behavioural therapy groups. Patients also had access to food, drinks and snacks throughout the day and we saw that staff offered patients a choice of meals.

Staff used health of the nation outcome scores to assess and record severity and outcomes and the waterlow score to estimate risk of the patient developing pressure sores however were not clear how this information was used after it had been collected.

Staff could not fully explain how they engaged in clinical audit however we saw that audits were being undertaken; for example the unit manager regularly conducted care records reviews. The unit's consultant psychiatrist and unit manager also engaged in clinical research.

Skilled staff to deliver care

There was a full range of health disciplines that input to the unit and a comprehensive induction programme for all staff, which included e-learning and face to face training. One member of staff on Naomi unit spoke highly of the induction. They were given a mentor to support them and introduce them to patients on the unit and were given information relating to meal plans, hydration plans and fire procedures. They also shadowed other staff members as part of their of the support worker care certificate. Staff were experienced and qualified to perform their role; they had completed mandatory training which was specific to their role. Average training compliance was 86% but the unit was below target on three training courses. All new staff received two day specialist training when starting on the unit. induction.

All of the permanent non-medical staff had received an appraisal between 1 August 2016 and 31 July 2017 and the consultant psychiatrist on the unit had been revalidated. The unit manager maintained a spreadsheet and had staggered the appraisals so that they were easier to manage.

Staff supervision rates were low on Naomi unit. Between 1 August 2016 and 31 July 2017 36% of staff had received supervision. The provider acknowledged these low rates and had asked that the unit manager complete all supervisions by December 2017. The current unit manager was temporary and a new unit manager and deputy unit manager was due to start in December. Group clinical supervision was held weekly for qualified nurses, support workers and multidisciplinary team staff. Staff confirmed they attended but this was not always recorded. Managerial supervision was scheduled monthly but this had not been maintained due to a lack of senior staff on the unit. The unit was reviewing the frequency of this. Staff also held team meetings where they received feedback; these were flexibly arranged so that the more staff could be updated on hospital wide news. Staff told us that they were also able to get support via formally arranged sessions.

Multidisciplinary and inter-agency team work

Naomi unit had a cohesive multidisciplinary team. This included nurses, support workers, social workers and dieticians as well as professionals from psychiatry, psychology, cognitive behavioural psychotherapy, occupational therapy, advocacy and physiotherapy. The unit held a multidisciplinary team meeting twice a week that patients and families were also invited to. Staff recorded discussions at the multidisciplinary team meetings and saved these on the electronic records system once the patients had agreed with the content.

We observed a handover meeting where staff were updated via a consistent approach that allowed staff to manage the patients' needs and risks. Information discussed was recorded and stored securely. Staff discussed a range of issues such as observation levels, Mental Health Act status, leave arrangements, current stage of recovery plan, group attendances and outcomes, physical health and medication. All staff were respectful, actively involved and listened. We saw that issues raised by patients were discussed and acted upon.

Naomi unit scheduled and held care programme approach meetings with care coordinators and community mental health teams four weeks after a patient's admission and every eight weeks thereafter. Patients told us they were fully involved and felt confident that they could ask for what they wanted. Staff told us that the service was reviewing the duration of the patients' pathway and the care model to better align with NHS England target of the 100 day pathway. Staff felt that there would need to be increased community input to be able to discharge patients in a more timely way. Staff explained that currently there were no issues with discharges as the home team, care coordinator and written referral form were in place before patients were admitted. This meant that local care arrangements were in place at discharge point.

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

Staff knew of the Mental Health Act advisor in The Retreat York and knew how to make contact for any support. The Mental Health Act office examined all paperwork on admission.

Specialist eating disorder services

All staff had completed mandatory training in the Mental Health Act and Code of Practice and understood the principles of the Act. Patients were informed of their rights on admission and we saw evidence of informed consent and discussion of treatment options recorded on the electronic records system; however patients could not recall further discussion of their rights. Patients also received an information booklet that they could refer to. Staff used nurses holding powers when patients were at risk. Staff have a duty under the Code of Practice to ensure that they assess an informal patient who wishes to leave the ward if they believe they are at risk to themselves or others in line with the authority they have under section 5(4) of the Mental Health Act. Risks were highlighted to all staff at handover and staff were informed when holding powers were used.

The Mental Health Act advisor had comprehensive monthly audits in place for use of urgent treatment, holding powers and temporary holds on informal patients. The service kept clear records of leave granted to patients. The provider's audit manager conducted additional audits including confirmation that the hospital had given information to detained patients, leave of absence from hospital and consent to treatment. Completed audits and documentation relating to the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards were reviewed by the Mental Health Act Law scrutiny group; this group comprised of each units' Mental Health Act champion. Detention paperwork was held securely by the Mental Health Act Law advisor but was also available via the electronic record system.

Patients had access to independent mental health advocates via local advocacy services if they wished. They are trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the Act and participate in decisions about their care and treatment.

Good practice in applying the Mental Capacity Act

On Naomi unit 89% of staff had received mandatory training in the Mental Capacity Act. Staff contacted the organisation's Mental Health Act advisor for additional support if required. There was a Mental Capacity Act and Deprivation of Liberty Safeguards policy available on the provider's shared network to refer to. Adherence to the Mental Capacity Act within the service was monitored via the audit lead at the Retreat York.

Staff explained that all of the patients on Naomi unit during the inspection had capacity. There were no episodes of restraint recorded on Naomi unit between 1 February 2017 and 31 July 2017; instead staff used de-escalation techniques to calm patients. If restraint was used then staff explained they would use low level arm holds for the minimum amount of time.

Are specialist eating disorder services caring?

Kindness, dignity, respect and support

We observed staff and patient interactions during the inspection on Naomi unit. We saw staff being respectful and courteous at all times. We observed eight patients having lunch and attended a post lunch support group where 10 patients attended. During lunch staff sat with patients that needed additional support and enjoyed a relaxed meal with the radio on; patients were given a choice of meals. At the post lunch support group patients spoke openly about their plans for the day, their thoughts and feelings in a supportive group setting. A recent place-led assessment was confident that the environment supported the dignity and respect of the patients.

We spoke with five patients on the unit and one family member who all said they felt safe on the unit. The units were clean and comfortable and patients could lock their rooms if they wished. Patients described the staff as supportive and approachable even when they were being challenged about their eating disorders. Patients told us that staff acted calmly and professionally at all times. We received one comment card from a patient saying the staff were very helpful and could not do enough to help.

The involvement of people in the care they receive

Patients told us about the admissions process. Prior to admission patients' were assessed and then orientated to the unit during visits. On admission they received a comprehensive admissions pack that included details of the program, boundaries and expectations as well as additional information such as the complaints process.

All patients told us that the unit worked collaboratively and involved them in their care planning. One patient described reviewing their care plan during a meeting with a nurse. Patients were invited to attend multidisciplinary team meetings and care programme approach meetings as were families and carers where patients consented.

Specialist eating disorder services

Patients held weekly business meetings where they were able to feedback and raise any issues on the service. All patients we spoke with felt that they could raise issues at this forum and would speak to the staff or unit manager directly. Patients were also invited to feedback via patient questionnaires, although the provider had recognised that no patients from Naomi unit had responded.

Patients accessed advocacy locally and patients were actively involved in staff recruitment and decisions which affected the service.

The unit recently held carers and family weekend where the safeguarding lead and unit consultant psychiatrist facilitated sessions that provided support for families and carers of patients with eating disorders.

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

Access and discharge

The average bed occupancy of Naomi unit for the period between 1 March 2017 and 31 August 2017 was 81%. When patients went on leave they were able to return to their rooms. There were no delayed discharges or readmissions to the unit between 1 March 2017 and 31 August 2017. The hospital reported that the average length of stay for patients on Naomi unit was 221 days.

Patients could be admitted from anywhere in the United Kingdom as Naomi unit was a specialist service commissioned by NHS England. The service had implemented a thorough referral to admission pathway for patients. Staff held weekly referrals meetings. Nursing staff and therapists held combined patient assessments, completed carers assessments and dietitian completed assessments. Outcomes were discussed at the referrals meeting and dates for admission were agreed. The unit followed a preadmissions checklist to ensure the admission process was followed and all staff groups were informed, including pharmacy and domestics. Discharge was included as part of the care programme approach process.

When a patient required a transfer to a psychiatric intensive care unit or acute mental health environment, the service liaised with the patient's home team care coordinator and informed the relevant funding authority. They confirmed that delays could occur when local trusts could not identify a bed immediately due to national shortages. The provider maintained close contact with home teams during this period and ensured that the patient received the level of support necessary to maintain their safety whist waiting for a bed.

The facilities promote recovery, comfort, dignity and confidentiality

Naomi unit had a full range of rooms available, including clinic room, therapy rooms, lounges and activity rooms. Patients could access a telephone on the unit to make private calls. Patients told us that there wasn't a room on the unit where they could meet with visitors; this was difficult when they didn't feel comfortable having visitors in their bedrooms. Patients could lock their bedrooms and belongings could be secured in a locked drawer in their rooms. The unit was clean and well maintained and patients were able to personalise their bedrooms. Patients could access the gardens depending on their progress on the recovery pathway; access was individually risk assessed. The unit had reorganised the dining room to improve the mealtime experience for patients which allowed for staff to better support patients while eating meals. Patients were able to use the mini kitchen to make hot drinks and access snacks 24 hours a day including weekends. Patients described the food as being of good quality and told us they had choices of meals. Patients had access to a menu at all times that set out the meals available for that week.

There was a timetable of activities that accommodated the individualised needs of the patients. Sessions included therapy options, healthy eating groups, self-catering and community outings. Between 12pm and 2pm the unit operated protected mealtimes that included a post lunch support group. There were also optional groups such as going to the gym, swimming, yoga, trips out, gardening and the choir that were available to patients. The service increased staffing levels to accommodate planned trips off the unit. There were no therapy groups at the weekend with the exception of the post meal support group. Patients told us that weekends were more relaxed. There was an activities board with activities seven days a week and patients were encouraged to go on trips off site at the weekend. Patients enjoyed accessing pet's corner where they kept and looked after a variety of animals; patients were able to bring their pets from home if they wished.

Specialist eating disorder services

Meeting the needs of all people who use the service

Naomi unit had a stair lift to enable patients that were minimising their energy use or those with mobility difficulties to access to the garden and the grounds.

The onsite catering facilities and staff were able to meet dietary requirement needs of any religious or ethnic background and vegetarians were catered for. Where a patient's dietary needs were specific or unusual and not provided for by the standard menu, the hospital would meet their needs on an individual basis.

There was access to a range of spiritual and faith support facilitated by the Retreat York's chaplain. The provider had a quiet room available for patients' spiritual needs. Leaflets were available which offered information and support in terms of spiritual health. The chaplain also facilitated groups

Information leaflets were available and accessible. There was information on treatments provided, local services such as advocacy, patients' rights and the complaints process. In order to communicate with non-English speaking patients the provider accessed a translator service via the telephone and could order information leaflets in other languages as required.

Listening to and learning from concerns and complaints

All of the patients we spoke with knew how to complain and details of the complaints process was in the unit information pack and leaflets were visible on the unit. The Retreat York had a complaints policy that acknowledged verbal, written and electronic complaints. There were three complaints between 1 August 2016 and 31 July 2017 on Naomi unit; one of which was upheld. No complaints were referred to the ombudsman. We saw that staff could refer to an information sheet on how to make a complaint in the duty room. Staff on the unit knew how to handle complaints in line with the policy and involved the safeguarding team when necessary.

We reviewed as selection of complaints from across the organisation during our inspection. The organisation had a governance framework and procedures in place to ensure that complaints and incidents were investigated and reported on. The complaints process was clearly defined with distinct timescales and the chief executive of the organisation signed all complaints. Learning was fed back via the provider's sharing and learning bulletin and via quarterly reports, however we did not see processes that reviewed if the lessons learnt had been embedded in the organisation.

Between 1 August 2016 and 31 July 2017, Naomi unit received 20 compliments; the unit had the highest number of compliments recorded in the organisation.

Are specialist eating disorder services well-led?

Vision and values

All staff spoken to understood the vision and values of the provider and we saw these demonstrated in staff behaviours. The Retreat York ran a values week that involved staff and patients in activities that supported the organisation's values.

The values of The Retreat York are:

- Equality and community
- hope
- care for our environment
- peace
- honesty and integrity
- courage.

The individual team objectives had been to achieve the quality improvement plan requirements and to ensure any changes were embedded within the culture of the unit. However the provider told us that future unit objectives would be determined within individual unit business plans, which will also reflect the overarching strategic objectives of the organisation.

Staff knew who the senior managers were within the organisation and confirmed they were visible on the units. The new chief executive had visited and shadowed staff on shifts and members of the senior leadership attended unit team meetings; staff spoke positively of the senior leadership team.

Good governance

The service had a training manager that recorded mandatory training set by the provider. Average training compliance was 86% on 31 July 2017, which is above the

provider target of 80%. However we found three courses were below the compliance target. Staff on Naomi received a two day induction that provided additional training into the unit's procedures and therapeutic approach.

All staff on Naomi unit had received an annual appraisal and the provider was staggering appraisal dates to ensure that work associated with appraisals was manageable for staff. Staff could access regular staff meetings and the unit manager arranged these around the flexible workforce's availability. Group clinical supervision was held weekly for qualified nurses, support workers and multidisciplinary team staff however the provider submitted data from the 31 July 2017 identified that only 36% of staff had received 1:1 supervision. Staff confirmed they attended group supervision but this was not always recorded. The unit manager was optimistic that supervision rates would improve when the new unit manager, supported by the new deputy unit manager, started in December.

There were sufficient staff on the unit that had appropriate experience and administrative staff supported unit staff with administrative tasks.

The unit worked as a therapeutic community and patients and staff discussed incidents and solved problems as cohesive group. However, staff could not provide any example of changes being made by the unit as a result of incidents or describe a formal process for ensuring learning from complaints or incidents from across the organisation outside of email updates and staff bulletins. Staff had good knowledge of safeguarding procedures, reporting procedures and how to identify abuse. Staff had been trained in the Mental Health Act and Mental Capacity Act.

The provider had recently restructured their risk register process so that all units had an individual unit risk register which escalated relevant risks to the corporate register. One staff member explained that staff had different responsibilities on the unit, for example leading on the unit risk register. Staff were able to add risks to their local register.

We saw evidence that Naomi unit measured team performance and reported on a quarterly basis. Documents were displayed on notice boards that identified the number of complaints, audit results, incidents, medication errors and compliments per unit.

Leadership, morale and staff engagement

The 2017 staff survey took place in February 2017 and reflected the provider as a whole, not specifically Naomi unit. The provider had developed an action plan which addressed each of the key areas.

- Confidence in the leadership team
- communication
- creating a positive working environment
- being seen to take staff safety seriously
- optimism for the future.

Actions had a designated lead and progress was monitored at weekly leadership team meetings and discussed with trustees of the board. We saw that actions to the survey were being implemented. For example, to improve confidence in the leadership team, members of the senior leadership team attended unit meetings and provided organisational updates in person. The Retreat York was rolling out a new intranet to improve communication and had attempted to improve communication with staff via different methods such as a 'rumour wall' to access staff who wanted to remain anonymous and informal sessions with the senior leadership in the staff canteen. However uptake of the sessions was poor and the rumour wall was unmoderated which meant that comments became personal and inappropriate. One comment card from staff specifically mentioned that they were impressed by the leadership team's determination to get The Retreat York to a place of maximum efficiency and care.

Staff felt valued on Naomi unit; however the lack of transparency over pay and pay structure was impacting on staff morale across all roles in the hospital. The provider was aware of this issue and was in the process of rolling out the 'living wage' for non-clinical staff. The Retreat York also intended to implement a salary review for other staff to be completed by the new interim director of human resources once appointed. The senior leadership team were in the process of re-evaluating the strategic direction of the organisation and were implementing 32 work streams to further improve the service and address staff morale; however staff we spoke with were not involved or aware of this improvement strategy.

Sickness and absence rates were 8.2%, above the organisation's inpatient unit average of 4.9%. Between 1

Specialist eating disorder services

August 2016 and 31 July 2017 12 staff left Naomi unit however the unit had recruited to vacant posts and had only one vacancy for a qualified nurse during the inspection.

Staff on Naomi reported good relationships with the unit manager and consultant psychiatrist and felt able to raise concerns or whistle blow without fear of victimisation. Staff were able to work flexibly and told us that there was always a friendly, welcoming feeling on the unit. They received a relevant induction and had lots of support from colleagues.

Staff had opportunities to develop on Naomi unit and the organisation sponsored open university courses for staff. The temporary unit manager had implemented a nurses' day to improve shared learning within the team giving staff protected time to tackle unit issues.

Staff were open and honest and could describe their responsibilities under the duty of candour when things went wrong. We saw that duty of candour was incorporated into the incident management system and safeguarding referrals.

Commitment to quality improvement and innovation

Naomi unit was recently reaccredited by the Royal College of Psychiatrists. The service had worked to address concerns relating to the physical environment**.** The Quality Network for Eating Disorder Adult Inpatient Standard standards are designed to reflect the experience of people using the services and look at all aspects of the service. The accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided. Staff on Naomi unit were also involved in clinical research programmes. The unit's consultant psychiatrist and unit manager were writing a paper for the Royal College of Psychiatrists on eating disorders and veganism and the unit had a research group that met monthly.

Personality disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are personality disorder services safe?

Safe and clean environment

Kemp and Acorn units were both located on the ground floor of the main building. This meant both units were accessible to patients who had mobility issues. Both units had a ligature risk assessment in place, identifying blind spots and areas where patients could not be seen. This meant there was an increased risk of harm to patients because the units contained ligature points. A ligature point is something, which people can use to tie something to in order to strangle themselves.

Kemp unit had several controls that mitigated ligature risks. There were door top alarms on all doors in isolated places. All isolated places had glass vision panels. There were zonal observations on the unit that managed individual risk and there was anti-ligature furniture in all bedrooms. Areas that had significant more risk, such as the skills kitchen and the art room, were on swipe card access and were risk assessed by staff for patient use.

Patients on Acorn unit were individually assessed to identify if they were at risk of self harm. The aim of the Acorn programme was to aid recovery and expose patients to risks that they would have to manage on discharge. Bedrooms and bathrooms had been fitted with anti-ligature furniture. Staff audited ligature risks on the unit and were considering the need for anti-ligature fittings for communal areas. All patients had an individual risk assessment. If a particular risk became apparent during a patient's stay, staff developed individual plans to manage these risks.

Patients on both units could access a quiet room referred to as the snug or chill out room. These rooms gave patients a safe place to go to if they were feeling anxious or upset. On Kemp unit, access to this room was via two locked doors so staff were required to open both doors before the patient could enter. The doors were always left unlocked when patients used the room so they were able to leave. The room had padded walls and soft furnishings chosen by patients. Kemp patients could also access a sensory room with special lighting, music, and sensory objects. This was located next to the 'snug' and required staff to unlock the doors to grant access. On Acorn unit, the chill out room was located on the main corridor and patients could access it at will.

Both units were female only and had no seclusion facilities. Staff told us that patients were not secluded. Staff said that if patients became agitated they would use distraction techniques until the patient became calm.

There was an alarm system in patient bedrooms, corridors and in all communal areas of the building. Staff and official visitors carried personal alarms for their safety. Both units had fully equipped clinic rooms to allow staff to examine and treat patients. They were clean and had accessible resuscitation equipment in date and ligature cutters; emergency drugs were checked regularly. Medicines were stored securely and access was restricted to authorised staff. Controlled drugs were stored safely in a dedicated controlled drugs cupboard.

The Retreat York had a children's visiting room available in a shared area in the main building which could be used should relatives bring children to visit patients.

Safe staffing

The Retreat York submitted nursing establishment whole time equivalents on Kemp unit between 1 May 2017 and 31 July 2017 as:

- Qualified nurse whole time equivalents: 11
- Support worker whole time equivalents: 20
- Number of vacancies of qualified nurse whole time equivalents: 6
- Number of vacancies of support worker whole time equivalents: 2.3

- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 9
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 85
- The number of shifts that had not been filled by bank or agency staff where there was sickness, absence or vacancies: 12

Staffing levels on Kemp unit were two qualified nurses and four support workers during the day and two qualified nurses and three support workers at night. The manager and deputy manager we supernumerary and could slot into shifts where staff had not turned up. We reviewed rotas and found these did not always reflect the recommended staffing levels. However, there were additional staff disciplines on the unit such as psychologists and occupational therapists for individual and group work who offered support. The manager was aware of the staffing issues on the unit and recognised the eight vacancies for qualified nurses affected the moral of other staff. They were working with their human resources department to try to find some stability until the vacancies were filled. This included offering agency workers 12 month contracts; one of the agency workers had worked on the unit since it had opened. The manager also ensured agency staff were included in training and supervision.

Between 1 August 2016 and 31 July 2017, the sickness rate on Kemp unit was at 4.6%. The provider also submitted figures of staff that had left the organisation from 1 August and 31 July 2017. On the Kemp unit, 13 substantive staff had left between these dates.

Staffing was described as an issue on Kemp unit by support staff, nursing staff and patients. Patients told us that nurses were not always visible on the unit although there was always a support worker available. We spoke with five staff members on Kemp unit. We observed and staff confirmed that a qualified nurse was present in communal areas of the unit at all times and that patients had regular time with their named nurse. Patients and staff said that groups were cancelled due to a lack of staff. Staff told us that if section 17 leave was postponed due to lack of staff it was always rearranged.

Staff told us that there was adequate medical cover day and night, and that a doctor could attend the unit quickly in an emergency. There was an internal duty doctor rota and the consultant psychiatrist on the unit explained that staff called for advice when needed.

Kemp unit followed the mandatory training as set by the provider. Average training compliance was at 87% exceeding the provider target of 80%.

The provider submitted nursing establishment whole time equivalents on Acorn unit during the period of 1 May 2017 to 31 July 2017:

- Qualified nurse whole time equivalents: 9
- Support worker whole time equivalents: 5.5
- The number of shifts filled by bank staff to cover sickness, absence or vacancies: 102
- The number of shifts filled by agency staff to cover sickness, absence or vacancies: 26
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies: 5

During the inspection the vacancies were:

- Number of vacancies of qualified nurse whole time equivalents: 2
- Number of vacancies of support worker whole time equivalents: 0

Day time staffing was one qualified nurse and two support workers, night time staff was one qualified nurse and one support worker. We viewed rotas and found these levels were maintained. There were additional staff disciplines on the unit such as psychologists for individual and group work. There was a vacancy for an occupational therapist for Acorn Unit who offered support, patients and staff both felt more staff were needed. The lack of occupational therapy support meant some groups were not available to patients.

Total numbers of substantive staff between 1 August 2016 and 31 July 2017 was 20, three staff left during this period. Between 1 August 2016 and 31 July 2017, the sickness rate on the Acorn unit was at 2.6%.

We spoke with four members of staff on Acorn unit. They all felt staffing levels were safe and where bank or agency staff were used, they were familiar with the patients and unit. During our visit, they had extra staffing because of doing one to one observations. Patients told us that the life skills group was cancelled occasionally because there was no occupational therapist available.

Patients on the unit said that staff were always available and responded immediately if they were in the office. We observed and staff confirmed that a qualified nurse was present in communal areas of the unit at all times and that

patients had regular time with their named nurse. Staff told us that there was adequate medical cover day and night, and that a doctor could attend the unit quickly in an emergency.

Acorn unit followed the mandatory training as set by the Retreat York. Average training compliance was at 95% this exceeded the provider target of 80%.

The exception to this figure was:

- Pronouncing an expected death of a patient. Only three of the eight staff had completed this training. However training was planned to ensure that all staff complied.

Assessing and managing risk to patients and staff

The Retreat York reported no incidents of seclusion or long-term segregation between 1 February 2017 and 31 July 2017. Kemp and Acorn units did not have seclusion facilities. There were five incidents of restraint involving patients on Acorn unit during this same period. Whilst Kemp unit reported 11 restraints on five patients, one of these resulted in prone or supine restraint. When the incident was concluded staff made a safeguarding referral to look at what happened. Other staff described the use of verbal de-escalation to prevent aggression when it occurred. The Retreat had introduced individual risk assessment using a patient led document called 'Respect my Wishes'. This document identified what techniques staff should use when patients were in crisis.

Restraint was used as a last resort and staff reported it via the incident reporting system. Care plans and risk assessments were changed to accommodate increased risk following discussion in a multidisciplinary meeting. The units worked within the provider restraint policy and worked towards the least restraint.

On admission, staff completed a functional analysis of care environments risk assessment for the patient. The functional analysis of care environments risk profile was included in the Department of Health's published guidance 'Best Practice in Managing Risk' (March 2009). Staff completed a further risk assessment every three months unless the individual patient circumstance means more are required as per the provider policy.

We viewed eight risk assessments for patients. Risk assessments were initially completed as part of the admission process where possible. As a patient progressed through the treatment programme, this was reviewed and updated in line with the provider policy. Risk was also discussed in multidisciplinary team meetings, formulation meetings and handovers should an incident occur and review of risk be required. Patients told us they were involved in any discussion about their care plan.

Acorn unit did not use routine observations on patients but all patients had risk assessments completed. Patients were encouraged to hold emergency meetings to seek advice from the therapeutic community when they felt at risk of harming themselves or others.

Kemp unit used zonal observations and placement of staff to cover blind spots. They also had a more detailed local standard operating process for observations for staff to follow. Staff completed an observations form when handing over to another staff member. Patient searches were conducted on Kemp unit only. The unit manager explained that they did not routinely search patients and only did so if the patient was considered to be at risk of harm to themselves or others; any searches conducted were explained to the patient and conducted in line with the provider's search policy. Patients had an individual risk assessment. These were reviewed monthly and informed the care that the patient received. Further, risk assessments were reviewed every time a serious incident occurred and were updated to reflect the current level of risk. Items that were identified as posing a potential risk (such as razors) were stored safely on the unit and could be accessed by patient on request and where the clinical assessment agreed with the request.

On Kemp unit, medicines were stored securely and access was restricted to authorised staff. Controlled drugs were stored securely and checks completed. Room and fridge temperatures were recorded daily and were within the recommended ranges.

Care plans were in place and detailed the needs of the individual. Self-medicating was tailored to the individual's needs, for example some people could have their medicines in their rooms. Consent forms and assessments had been completed and compliance was assessed regularly. For others the staff held the medicines in the treatment room, but patients attended and took the medicines at the appropriate times of day to help engage the patient in self-care.

On the Acorn unit medicines were stored securely with access restricted to authorised staff. Fridge and room

temperatures were recorded daily and were within recommended ranges. Medicines card audits were completed weekly for all patients and actions identified and discussed with unit manager. Medicines competency assessments had been completed annually and all staff were up to date.

Care plans were in place, which detailed individual requirements for safe administration and medicines management. Care partner entries were also made for missed doses and these gave details about why medicines had been coded as not administered.

We checked the equipment and medicine stored for emergencies on each unit and found all items were fit for use. Daily checks had been completed for the defibrillator on all the units.

The medicines code was reviewed in line with the governance arrangements for policy review and the pharmacist was part of this process. The Pharmacist actioned and disseminated medicines alerts, recalls, and reviewed incidents. The pharmacy team did not have access to the incident reporting system but this was under review. All incidents were reviewed in the clinical governance group as a standard agenda item and a pharmacist attended these meetings.

Medicines related audits were completed on a daily and weekly basis by unit staff with larger pharmacy led audits taking place as part of the overall audit schedule. An invitation for pharmacy staff to the managers meeting had occurred in light of the audits and this was an integral method of communication and ongoing learning.

Medicines care plans were reviewed regularly and were patient focused detailing core medical concerns and how these conditions could be managed through medicines. A psychotropic drug monitoring form had been developed to aid prescribers and clinical staff to track the monitoring requirements for medicines. Pharmacy staff were well embedded in the clinical aspects of care at The Retreat York with good methods of communication between unit staff and the pharmacy team.

Staff were trained in safeguarding and most knew how and when to make a safeguarding alert. Substantive staff described when to raise a safeguarding alert. On Kemp unit, 83% of staff had completed the Safeguarding Adults General Awareness, and 86% had completed Child Protection Core Level 3 training. On Acorn unit, all staff had completed Safeguarding Adults General Awareness, and the Child Protection Core Level 3 training. There were good links with the local authority, this was confirmed by both staff and local authority, and care and treatment records also reflected safeguarding concerns. The Retreat employed social workers and they were available on the units to facilitate groups, available to patients and managed the safeguarding referrals.

Track record on safety

There were 2,332 incidents reported from the units within the Retreat York between 1 August 2016 and 31 July 2017, and 638 (29%) of these incidents were reported by Kemp unit. Incidents related to self-harm, slips trips and falls and violence and aggression.

Reporting incidents and learning from when things go wrong

Staff told us they reported incidents and accidents electronically. They had a personal account from which they were able to report incidents and raise safeguarding alerts. An incident report form had to be completed within 24 hours of an incident occurring. The incident was then logged within the incident database and given an 'incident number' as a reference. Incident alerts automatically generated an email that immediately informed the appropriate managers or leads of the incident so that any immediate action could be taken. A daily incident report was generated each morning, and was delivered via email to the senior leadership team (directors), the unit managers and senior members of the multidisciplinary teams that were directly involved in the care of patients. This report detailed all the incidents that had occurred within that 24 hour period. Safeguarding alerts were not circulated wider than the Retreat York social work team and the risk and quality officer. The daily incident report informed any further action that was to be taken including and not limited to:

- Serious incidents requiring further investigation
- safeguarding alerts
- care quality commission notifiable incidents
- notifications to commissioners
- reporting of injuries, diseases and dangerous occurrences regulations 2013 reportable incidents.

The unit manager on Acorn unit told us that incidents were discussed in morning community meetings and, with patients input; they looked at what could be improved. Staff told us that feedback was received at daily report out

team meetings or via emails and that 30 minute daily debriefs were held after their shift. Staff on Kemp unit also had protected time from noon until one; this allowed for debriefings, learning and supervisions to take place. The consultant psychiatrist from Kemp unit told us that the unit had created an individualised patient information sheet to share key information with agency staff to prevent incidents occurring.

The Kemp multidisciplinary team held a weekly team meeting to discuss individual patients and assess their risk. This included a patient's risk of engaging in self harming behaviours. In addition to this, a daily 'report out' on the Kemp unit highlighted emerging risks for individual patients, which could include self harm. This was documented on the electronic patient records system and informed and updated their care plans and risk assessments.

The Acorn unit had local risk protocols that offered guidance to patients on how to take control of their own risk. Any incident of self harm was followed by 'stabilisation'. Patients were expected to engage in a 'behavioural analysis', in which they looked at what led up to the incident and ways to handle things differently next time. This process was discussed openly within the Acorn community. On the Acorn programme, when patients felt they were at risk of engaging in risky behaviour they could request skills coaching from staff. In addition to this a 'support meeting' could be called where the community comes together to support the individual to reduce their vulnerability and access skills.

Duty of Candour

Incident reporting forms incorporated a duty of candour section and staff were aware of the provider's policy and their responsibilities within this requirement. Staff on both units were open and honest and could describe their responsibilities under the duty of candour when things went wrong.

Are personality disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

We reviewed eight care and treatment records, which were held on the provider's electronic system. The files were secured by a password and only accessible by staff. Non-contracted agency staff had to ask permanent staff to log on to the computer so they could add their notes to the electronic record. When no one was available, records were made on paper, which could lead to information being missed. The administrative support staff collected paper records from the units and scanned these onto the electronic record system to mitigate the risk. All patients had a comprehensive assessment completed after admission.

We saw regular reviews of the care plans on file. All records showed evidence of physical heath checks being completed on admission to the units and ongoing reviews of blood results being completed by staff. Patients' physical health was monitored regularly and in line with their care plan.

Patient care and treatment plans were personalised and holistic; we saw that they reflected patient preferences and promoted independence, including when in crisis. We saw evidence that care and treatment plans identified individual support strategies and areas for skills development. All plans were written in the patient's voice.

A local GP and practice nurses attended the units regularly to conduct patient health checks. They had direct access to the electronic recording system so they could record their visit. Paper records such as blood results were scanned in to the patients file.

Best practice in treatment and care

When Kemp unit was established, they followed international guidance due to an absence of national institute for health and care excellence guidance relating to dissociative identity disorder,. The structured clinical management group used practices from 'Borderline Personality Disorder - An evidence-based guide for generalist mental health professionals' written by Anthony W. Bateman and Roy Krawitz in 2013. As there is no national institute for health and care excellence guidance about dissociative identity disorder the consultant psychiatrist followed international guidelines such as the European Society for Trauma and Dissociation and the International Society for the Study of Trauma and Dissociation. As a result of the lack of evidence based guidance on dissociative identity disorder The Retreat York were developing their own guidance including developing a business plan for trauma informed care. The Pottergate Centre for Dissociation and Trauma centre had recently

carried out an assessment of the work carried out on Kemp unit and the results were positive. The Pottergate Centre for Dissociation and Trauma Centre specialises in dissociated states and provides training and links to their professional services for professionals who work with patients who have dissociative identity disorder.

Kemp unit engaged with and care planned the patients' multiple states whereas the Acorn unit patients learned to co-exist with their different states. There was no transition model for patients moving along the pathway from Kemp to Acorn units. However, during our inspection staff informed us that there had been a review of the work on Acorn. A proposal had been put to the unit however changes that would align Acorn unit with Kemp unit had not been agreed at this time.

Acorn unit followed a therapeutic community model where patient's shared their daily life with others on the unit and took responsibility for sharing decisions about their lives. Acorn unit had structured group work which followed a dialectical behavioural therapy model. Dialectical behavioural therapy helps patients to change unhelpful behaviours; it places particular importance on the relationship between the patient and the therapist, the emphasis on motivating the patient to change. Kemp unit had structured group work which followed a cognitive behavioural therapy approach. Patients on Kemp unit accessed trauma specialists, interpersonal therapies and compassion focused therapy to help manage relationships. Both units had access to the psychology team that consisted of both psychologist and assistant psychologists.

Staff on both units used health of the nation outcome scales to assess and record severity and outcomes, and the Waterlow score to estimate risk of the patient developing pressure sores. Kemp unit also used the recovery star to measure patient outcomes.

Patients had access to food, drinks and snacks throughout the day and we saw that staff offered patients a choice of meals on both units. Patients on both units told us the portion sizes were too small and there was not always a choice.

Unit managers told us that staff completed audits on each unit including weekly audits of lithium medication. Kemp and Acorn units audited medicines charts, reviewed dates, storage and labels as well as fridge and room temperatures. Both units also audited record keeping and Acorn unit conducted an audit on care of patients with borderline personality disorder against national guidance.

Skilled staff to deliver care

The service worked as a multidisciplinary team that included nurses, support workers, psychiatrists, psychologists, cognitive behavioural therapists, art therapists, dieticians, occupational therapists, advocates, involvement worker, pharmacists, physiotherapists, and social workers.

The Retreat York submitted appraisal data prior to the inspection. On Kemp unit, 85% of non-medical staff had received an appraisal in the last 12 months up to 31 July 2017. On Acorn unit, 96% of non-medical staff had received an appraisal for the same period. However, on Kemp unit only 30% and on Acorn unit only 60% of staff had received 1:1 clinical supervision in the 12 month period up to 31 July 2017. Staff on Kemp unit had an hours protected time each day that allowed for group supervision to take place and weekly group supervision sessions were held on Acorn unit. 1:1 clinical supervision targets had been set for each unit to achieve 80% by October, 90% by November and 100% by December 2017. Doctors on the units had all completed their revalidation.

There was an induction programme for all staff which included e-learning and face to face training; support worker training also covered aspects of the support worker care certificate. There was an organisational induction and a local induction carried out on the units.

Staff told us that they had access to additional specialist training suitable to their role. Qualified staff received dialectical behaviour therapy training. Staff working on Kemp told us they had completed training in personality disorder knowledge and understanding framework and training in dissociative identity disorder.

Staff on both units said that training was mainly internal but that it was accessible and flexible.

Staff on Kemp unit told us that the psychiatrist provided a two day and one day refresher day in dissociative identity disorder. Staff also had protected time each day from noon until one. This time was for further training and on the day of the inspection, the psychologist held a session about the patients' crisis plans for when they had disassociated. Staff told us this time could also be used for discussing issues on

the unit, for supervision and for training. They had also attended dissociative identity disorder training and training in motivational interviewing, compassion focused therapy and interpersonal therapy. Additional specialist training could be requested by staff, for example, one staff member had attended eye movement desensitization and reprogramming training.

We saw evidence that staff performance was monitored at unit level and that concerning performance or incidents were investigated and managed by the unit leadership team.

Multidisciplinary and inter-agency team work

The personality disorder services had regular and effective multidisciplinary meetings. Kemp unit held daily report out meetings at the beginning of the shift for all of the multidisciplinary team. We observed a meeting and saw that all patients and their risks were discussed. In addition to this, handovers occurred two or three times a day at the beginning of each shift on both units; handover frequency reflected differing staff shift patterns. On Acorn unit, a daily meeting was held with the patients where they discussed how their behaviours and actions had affected the unit. After the meeting staff from Acorn (swear) unit met to discuss any issues that had arisen. On Kemp unit there was also an additional two-hour meeting every Thursday where patients were reviewed in depth. One psychologist described how they attended the multidisciplinary meetings, supported with formulation and offered psychological interventions when required.

The psychology team also supported the units with behaviour management plans and identified and managed triggers to behaviour. Allied health professionals on the unit attended review case management meetings weekly. Staff on Acorn unit described the multidisciplinary team as close and supportive.

We found effective links with other organisations in terms of discharge planning. Staff described that involvement from external organisations could be difficult as patients were admitted from all over the country. The manager on Kemp unit explained that where possible community care coordinators attended care programme approach meetings and described the current patient group demographic. We reviewed eight care and treatment records and saw there was evidence of discharge planning in all of the records. We also saw details from care programme approach meetings and reference to difficulties of liaising with a home treatment team on Kemp unit. We found that the provider's social worker team were highly involved and patients had good links with local social services, particularly in terms of safeguarding.

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

On Kemp unit, 100% of staff and 88% of staff on Acorn unit had received training in the Mental Health Act; this was part of their mandatory training and was scheduled to be refreshed every three years.

Staff on these units confirmed that training had been completed in line with the Code of Practice, 2015. Staff explained the role of the Mental Health Act advisor in The Retreat York and knew how to make contact for any support. The Mental Health Act office examined all paperwork on admission. Staff told us that consent to treatment forms were attached to medication charts when required. We reviewed eight care and treatment records and saw evidence of capacity to consent to medication and certificates of second opinions being recorded. We saw evidence of patients having tribunals and notes of these in the care records.

Detention paperwork was stored with the Mental Health Act office and staff had access to an electronic copy. The manager of the Kemp unit told us that that if a patient wanted to leave the unit, and it was unsafe, they would attempt to discuss this with the patient but would use the nurses holding power, section 5.4, of the Mental Health Act as a last resort. However, during the inspection we found that an informal patient had been restrained by staff. The staff member involved in the restraint told us they had not considered assessing or using section 5(4) of the Mental Health Act 1983 to prevent the patient leaving the hospital at a time when it was deemed unsafe for them to do so. The nurse reported this was because the patient had an advanced statement that said they were not to be detained if possible and they believed they acted in the best interests of the patient. Following this action a safeguarding referral was made to the local authority and legal advice was sought by the provider.

Informal patients received a leaflet regarding their rights and the patients' named nurse held regular conversations with them to ensure they understood their rights. Staff explained patients' rights under the Act to them on a regular basis, and a local advocacy service provided support to the patients. The advocates were trained to

work within the framework of the Mental Health Act 1983 to support people to understand their rights and participate in decisions about their care and treatment. We observed posters on the units with contact details for the advocacy service.

Patients' families were involved in their care, when agreed by the patient, and their contact details clearly documented on care records. The Mental Health Act advisor produced twice yearly bulletins that were emailed to staff to update any changes in policy or law. The Mental Health Act advisor had comprehensive monthly audits in place for use of urgent treatment, holding powers and temporary holds on informal patients. The provider's audit manager conducted additional audits including ensuring information was given to detained patients, leave of absence from hospital and consent to treatment.

Good practice in applying the Mental Capacity Act

On Acorn unit 95% of staff, and 97% of staff on Kemp unit, had received mandatory training in the Mental Capacity Act. The provider had a Mental Capacity Act and Deprivation of Liberty Safeguards policy available on the provider's shared network for staff to refer to. Staff explained that they contacted Mental Health Act advisor in The Retreat York for any support. Staff were seen to have a good understanding of Mental Capacity Act 2005 and were aware of the five statutory principles.

Staff on Acorn unit said that the Mental Capacity Act was not often used, as patients were informal and had capacity.

On Kemp unit, the psychiatrist told us they were looking at using the Mental Capacity Act for patients when they had dissociated as they may lack capacity dependent on which dissociative state was presenting. Other staff we spoke with on the units confirmed that capacity was assumed unless there was a reason to suggest otherwise. Adherence to the Mental Capacity Act within the hospital was monitored via the audit lead at the Retreat York.

During the period of 1st August 2016 to 31st July 2017 the provider undertook the following audits within the Mental Health Act Category relating to the Mental Capacity Act:

- Audit Number 1: Mental Capacity Act (November 2016)
- Audit Number 2: Mental Capacity Act Re-audit (June 2017)

Are personality disorder services caring?

Kindness, dignity, respect and support

We observed staff to be thoughtful, kind and caring towards the patients. Interactions between patients' and staff were seen to be respectful and positive. On Kemp unit staff interacted with the different dissociated states that presented.

We spoke with eight patients and they told us that staff saw them as individuals and people not as a condition. They told us they felt comfortable with familiar staff and sometimes struggled because of the use of agency staff. Patients thought that agency workers were not always helpful and sometimes lacked the knowledge to work on the unit. Patients told us they could tell staff if they did not want a male or female member of staff and that staff listened to them at all times. We did not receive any comment cards for either Acorn or Kemp unit.

The involvement of people in the care they receive

We saw that all patients received a patient information pack which contained useful information including: a description of the service model, the philosophy of the unit, compulsory groups with timetable, details of the roles of the multidisciplinary team, smoking arrangements, contact with families and friends and information on how to make a complaint. Patients also received a leaflet that described what to expect in the first 48 hours of admission to the units. This included photographs of staff and the units and described the facilities and admission process. A schedule for the day was also included. Patients confirmed that they had received an orientation to the unit.

Patients told us they were involved in all aspects of their care and knew how to make a complaint or appeal against their section. We saw evidence of staff reading patients their rights and patients could have a copy of their care plan if they wished. Patients were encouraged to keep a copy of their crisis plan in their room so that staff and their peers could access it when they were in crisis. There was information on the unit about advocacy and where necessary they had accessed the service. In the last 12 months, the advocacy service had moved to an independent base, historically this service had been based within The Retreat York. Patients on both units were involved in recruitment processes.

Personality disorder services

We reviewed eight care plans and found that they were written in the first person and contained detailed information pertinent to the patient. Care and treatment records were signed as agreed by the patient. The records showed family and partner involvement where it was applicable and always with the consent of the patient.

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

Access and discharge

Between 1 March 2017 and 31 August 2017 the average bed occupancy of Acorn unit was 55% and for Kemp unit it was 92%. The average length of stay for Acorn unit was 216 days and for Kemp unit was 126 days. This is well within the one to three years guidance for long term rehabilitation provided by the Royal College of Psychiatrists. The maximum length of stay on Acorn unit was 12 months, and on Kemp Unit 18 months, with the last four months being used to focus of rehabilitation in the patient's own local area.

When patients went on leave, they were able to return to their rooms. We saw that care and treatment records referred to aftercare services where appropriate. The provider reported that neither unit had any delayed discharges. Both unit managers told us that they were able to, and had in the past, refused new admissions to the unit as the patient mix was not suitable.

Admissions and discharges to both units were planned and managed in a timely manner. The provider explained that when a patient required a transfer to a psychiatric intensive care unit or acute mental health environment, they liaised with the patient's care coordinator and the local crisis team. They confirmed that delays occurred as trusts could not always identify a bed immediately due to national shortages.

The facilities promote recovery, comfort, dignity and confidentiality

Activities on Kemp unit were delivered to the patient group and/or in one to one coaching formats as appropriate. Activities included dialectical behaviour therapy skills training groups, emotion regulation and management, cognitive behavioural therapy relation specifically to fear, anxiety, anger and sadness. Activities also included borderline personality interpersonal skills, understanding and coping with dissociation, ego strengthening resources and coaching compassion focused therapy group art and creative therapies including movement, drama and music.

Arts and crafts, board games and puzzles were also available on both units. There were also optional groups on both units such as going swimming, yoga, scrapbook group and Friday fun. Patients enjoyed going to pet's corner where they kept and looked after a variety of animals on The Retreat York site. They also accessed animal therapy via a local charity on a monthly basis.

Meeting the needs of all people who use the service

Both units were on the ground floor and patients who had mobility issues, and required equipment to assist them, could access the units. The onsite catering facilities and staff were able to meet dietary requirement needs of any religious or ethnic background. Where necessary a dietician worked closely with the catering team. On Saturdays patients were offered a cooked breakfast and Sundays and holidays were marked with traditional lunches. Patients were able to meet with the catering team and request dishes be added to the menus and were able to offer their views on the quality of the food.

We saw evidence that patients with special communication needs were supported through a range of actions for example; for patients with autism staff used different colour paper dependent of what worked best for the individual and they provided all documents in word format to another patient so they could use a document reader and listen to the information written. This meant that patients could be fully involved in their care planning.

There was access to a range of spiritual and faith support facilitated by the Retreat chaplain. The chaplain worked with patients on Acorn unit and held mindfulness sessions for the patients. The chaplain incorporated different patient's faiths into services. The provider had a quiet room available for patients spiritual needs; it was intentionally not referred to as a prayer room as the room was available to all. We viewed a leaflet for patients that offered information and support for spiritual health at the Retreat York.

Information leaflets were available but we did not see leaflets in different languages. However, staff told us these were available if required by a patient. In order to communicate with non-English speaking patients the provider accessed a translator service via the telephone.

Listening to and learning from concerns and complaints

Patients confirmed they knew how to complain and details of the complaints process was in the unit information pack, leaflets and feedback books that we viewed on the unit.

The Retreat York's complaints policy accepted concerns via verbal, written or electronic means. Between 15 March 2017 and 16 May 2017, the Retreat received seven complaints relating to the Acorn Programme. The complaints were made by clients of the Acorn Programme, relatives of clients of the Acorn Programme and on one occasion a commissioning body. In response to this increase in the number of complaints received, the Retreat carried out an internal investigation to identify any themes in the nature of the dissatisfaction experienced by the complainants, address any changes that were required and learn any lessons. The investigation identified a number of areas that that appeared to have contributed to the dissatisfaction of the complainants with the Acorn Programme. These were; deviation from accepted practices and protocol, incomplete documentation, information to staff and clients lacking clarity, communication with stakeholders. Actions to make sure these issues did not reoccur were identified and the progress of these actions was being monitored through the quality panel. Acorn unit also had a concerns book; this allowed patients to register grumbles and anything that was upsetting them if they did not want to make a complaint. These issues were discussed with staff and patients.

There were four complaints logged for Kemp unit. One was withdrawn; two were not upheld, whilst one was upheld. The complaint upheld raised concerns about the use of agency staff and night staffing. The unit manager acknowledged that the use of agency nurses could be disruptive to the service but they also told us that at least one of the agency nurses used had worked on the unit since it had opened. The unit manager was working with the human resources department to provide long term contracts to agency nurses to allow for stability on the unit until the vacancies could be filled. Information about complaints made were discussed in unit business meetings.

Are personality disorder services well-led?

Vision and values

All staff spoken to understood the vision and values of the provider. The values of The Retreat York are:

- Equality and community
- hope
- care for our environment
- peace
- honesty and integrity
- courage.

The values were embedded on the units and were incorporated into the ethos of the unit.

All staff spoken with knew who the senior managers were within the organisation and confirmed they were visible on the unit. Members of the senior leadership group regularly attended unit business meetings and staff felt they could approach them to raise any concerns or to offer suggestions about the work.

Good governance

The Retreat York had a training manager who recorded and scheduled mandatory training for each unit. Training figures for medicines management were above 87%.

Supervision and appraisals for staff were taking place. Acorn unit's appraisals for non medical staff was at 96% and Kemp unit was at 85%. However, 1:1 clinical supervision was at 60% for Acorn and 30% for Kemp unit. On Kemp unit, an hour a day was allocated to protected time which allowed for debriefings, learnings and group supervisions to take place. Weekly group supervision was attended by staff on Acorn unit. The provider told us that all staff would have received 1:1 supervision by December 2017.

Between 1 May 2017 and 31 July 2017, 12 shifts were not covered on Kemp unit and five on Acorn unit. The largest use of agency staff remained on Kemp unit; this was identified as an issue at the last inspection. However, the

provider has taken positive steps to fill their vacancies and where agency staff have had to be used they have used short term contracts to ensure the same staff are available. They covered 85 shifts with agency staff during this period.

Staff were undertaking some clinical audit on the units and the provider supported the units by undertaking overall audits of areas such as the Mental Health Act.

Staff had good knowledge of safeguarding procedures, reporting procedures and knew how to identify abuse. Staff had been trained in and evidenced knowledge of the Mental Health Act and Mental Capacity Act. Staff could also submit items to the local and provider risk registers.

Leadership, morale and staff engagement

A staff bi-annual survey had been carried out and the survey carried out in the second quarter of 2017 had a response rate of 48%.

The Retreat York had a dedicated involvement team; however a new team is being organised. The main role was to ensure patients were involved in their own care, service development and regional and national agendas. The governance structure included an involvement forum (quarterly), friend's family and carers forum (Quarterly), one to ones with patients, workshops for projects and carer support groups. Issues raised could be escalated to the leadership team as they attended the involvement forum and a member of the leadership team line manages the involvement lead.

A family and friends survey was conducted in September 2016 and there was a 45% response and of those 84% said they would recommend The Retreat York and nine per cent would not.

Sickness and absence rates were reported as 4.6% on Kemp unit and 2.6% on Acorn unit. There had been an issue with staff retention on the units. Kemp unit had 13 staff leavers since opening in May 2016 (20%) and Acorn unit had three staff leavers in the last twelve months (20%).

Staff told us that there was no bullying or harassment, they loved their jobs and felt lucky to work at the Retreat York. They described good working relationships with the unit managers and senior multidisciplinary staff. Staff felt able to input ideas for patient support as well as their own roles. They also praised the open and honest approach to teamwork that the unit had. Clinical leads were proud of the levels of compassion and empathy that staff had for patients.

Teamwork was evident throughout the inspection when we spent time observing staff on all units. Staff supported each other and offered help to ensure the best outcome for patients. Staff told us that they felt supported by their colleagues and the wider multidisciplinary team. It was evident when observing staff with patients that they enjoyed their jobs and were compassionate towards the patients they were working with. Unit managers were supportive of their teams and passionate about how hard staff worked with patients. Unit staff described patients as a priority and spoke highly of the involvement office whose role was to make sure that patients' voices were heard. Unit managers told us of opportunities for development and described leadership training led by an organisational development consultant.

Commitment to quality improvement and innovation

The Community of Communities has accredited Acorn unit for 15 years which was due to run until June 2019. The Community of Communities is a quality improvement and accreditation programme for therapeutic communities in the UK and overseas. This accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service provided.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they comply with their duty under the Code of Practice to ensure that they assess informal patients that wish to leave the ward if they believe they are at risk to themselves or others in line with the authority they have under section 5(4) of the Mental Health Act. This should be considered even if a patient has made an advanced statement about their care.
- The provider should continue to develop clear models and care pathways for the older adults units.
- The provider should ensure all forms of staff supervision are attended and recorded.
- The provider should ensure the delivery of the Strategic Business Plan that incorporates staff involvement, robust workforce modelling and financial planning.
- The provider should ensure that all mandatory training compliance meets the provider target for all staff on all units.
- The provider should ensure that all checks to test equipment and fire procedures are up to date.
- The provider should ensure that all nurses consistently document medicine related information in the patient's electronic record.
- The provider should ensure that unit staff are kept informed of the progress of applications for Deprivation of Liberty Safeguards.
- The provider should improve the privacy, dignity, respect and confidentiality arrangements for bedroom doors, patients dining experience and visiting arrangements.
- The provider should ensure ongoing review of restrictive practices and the embedding of lessons learnt from complaints and incidents.