

Newton House

Quality Report

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

Ratings

Overall rating for this location

Good



Are services safe?

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 Newton House as GOOD because:

- The service provided safe care. The unit environment was safe and clean. The unit had enough staff to deliver care and treatment. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare.
- The service worked to a recognised model of mental health rehabilitation. It was well-led and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working-age adults	Good 	Start here...

Summary of findings

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Good 

Newton House

Services we looked at

Long stay or rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Newton House

Newton House is a 21-bed longer term high dependency rehabilitation unit. The service provides rehabilitation and treatment to males aged over 18 who are living with complex and enduring mental health issues. There were 15 patients at the time of our inspection

The service has been registered with CQC since May 2014. It is registered to provide assessment or medical

treatment for persons detained under the Mental Health Act 1983 and for the treatment of disease, disorder or injury. The service had a nominated individual and registered manager in place.

The service was inspected in March 2016 and November 2017. The service was rated good overall on both occasions.

The service had a CQC MHA Review visit in October 2019. There were no significant concerns identified.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and one specialist advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with deputy manager
- spoke with 11 other staff members; including the consultant psychiatrist, nurses, recovery workers, occupational therapist, psychologist, cognitive behavioural therapist, social worker and risk and safety officer
- looked at five care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with six patients as part of our inspection. Patients were positive about the care and treatment they were receiving. Patients described being involved in decisions about their care and treatment. They told us that staff were caring and supportive.

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?

We rated safe as good because:

- The unit was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. Staff participated in programmes to reduce restrictive interventions.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The unit had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Good



Are services effective?

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to

Good



Summary of this inspection

psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to had good access to physical healthcare and supported patients to live healthier lives.

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The unit included or had access to the full range of specialists required to meet the needs of patients on the unit. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The unit had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Good



Are services responsive?

We rated responsive as good because:

Good



Summary of this inspection

- Staff planned and managed discharge well. Discharge planning started from admission and involved multi-disciplinary input. Staff liaised with commissioners, local care teams and services that would provide aftercare in order to promote discharge.
- The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. They understood their roles and responsibilities under the Act and Code of Practice and discharged these well. Staff had access to guidance and specialist advice.

Patients were informed of their rights on a regular basis. The service completed regular audits of Mental Health Act documentation and responded to any identified concerns. Mental Health Act documentation we reviewed was complete and appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in and had a good understanding of the Mental Capacity Act and its five guiding principles. They followed these in their delivery of care. Staff had access to guidance and specialist advice.

Staff assessed patient capacity on a regular and decision-specific basis. Best interest decisions were made

in line with guidance. The service completed regular audits of Mental Capacity Act documentation and responded to any identified concerns. Capacity assessment and best interest decision documentation we reviewed was complete and appropriate.

Long stay or rehabilitation mental health wards for working age adults

Good 

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

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

Good 

Safe and clean environment

Staff maintained the safety and cleanliness of the building. The unit was safe, clean, well equipped and well maintained. Cleaning records we reviewed were up to date and demonstrated that the ward areas were cleaned regularly. Staff completed regular risk assessments of the care environment.

The building layout did not allow staff to observe all parts of the unit. The service mitigated this risk with staff presence, risk assessment, observations and the use of convex mirrors and CCTV. Ligature risk assessments had been completed. Ligature points had either been removed or the risk was adequately mitigated.

Staff adhered to infection control principles to try and prevent the spread of infection. There were hand gel dispensers at the entrance to each ward which staff and visitors were prompted to use these. Infection control information was displayed around the ward. Staff had access to personal protective equipment.

The clinic room was appropriately equipped including an examination couch and accessible resuscitation equipment. Staff maintained equipment well and kept it clean. Clean stickers were visible and in date. Staff completed audits of the clinic room and equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. Staff operated a two-shift pattern. The day shift ran from 7:45am to 8:00pm and was staffed by a minimum of two qualified nurses and four recovery workers. The night shift ran from 7:45pm to 8:00am and was staffed by a minimum of one qualified nurse and four recovery workers.

The service employed six qualified nurses and were recruiting to a vacancy that was due to be filled in January 2020. The service employed 16 full time recovery workers and at the time of our inspection was using 8 bank recovery workers. The service was due to interview six recovery workers for permanent posts in the two months following our inspection. In addition to this the service employed a manager, deputy manager, consultant psychiatrist, psychologist, psychology assistant, cognitive behavioural therapist, occupational therapist, two occupational therapy assistants, social worker and support staff including two chefs, a Mental Health Act administrator and two risk and safety officers.

The service had access to regular bank staff and the manager was able to adjust staffing levels to take account of client numbers, complexity and mix. The service utilised a staffing matrix linked to occupancy and levels of acuity. Bank staff had received an induction to the service and were familiar with the service and the patient base. At the time of our inspection the service was using one agency staff member to cover night shifts. The staff member had been block booked to ensure consistency for patients. The staff member had received an induction and supervision whilst working at the service. The use of agency was set to end in January 2020.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staffing levels were sufficient to provide clients with regular one-to-one time. Planned activities and sessions had not been cancelled due to staff shortages. Staffing levels supported patients to access recovery orientated activities both on the unit and within the local community. There were enough staff, trained in appropriate skills to carry out physical interventions such as observation or restraint when required.

Mandatory Training

Staff completed a programme of mandatory training in key skills. There were 12 training programmes identified as mandatory for all staff including health and safety, fire safety, food hygiene, manual handling and the management of violence and aggression. Compliance with training varied across courses. Overall compliance was 85%. Staff compliance was monitored by the manager and staff sent reminders when training was due

Assessing and managing risk to patients and staff

Staff used a recognised risk assessment tool to identify, record and manage risk. We reviewed five care records. All five records contained comprehensive risk assessments that were reviewed regularly and up to date. Identified risks were captured in risk management plans which included actions to manage, mitigate and reduce the risk.

Information on risk was shared through documentation and in shift handovers and multi-disciplinary meetings. Staff were aware of and dealt with any specific risk issues. They responded to changing risks to, or posed by, patients.

Staff followed good policies and procedures for the use of observation including to minimise risk from potential ligature points and for searching patients or their bedrooms. Restrictions were individually assessed and reviewed regularly. There was one blanket restriction in place relating to energy drinks not being allowed on the unit. This was due to the impact consumption of the drinks had had on patient's mood, stimulation levels and weight. Patients were still able to access and consume energy drinks whilst on leave.

The service reported 39 incidents of restraint between the 1 March 2019 and 31 August 2019. This broke down as 26 incidents that equated to low level restraint including verbal de-escalation and supporting arm holds to guide patients away, five incidents classified as medium level where a restraint hold was applied, and eight incidents

classed as high level where more than one staff member or restraint hold was involved. None of the incidents involved prone restraint. There had been a peak in incidents during June and July 2019 related to one patient who was transferred to a psychiatric intensive care unit.

There was a programme to reduce restrictive interventions. All incidents of restraint were reviewed in a weekly multi-disciplinary meeting led by the psychology team. Case formulation and reflective practices were being undertaken. Learning was identified and shared. Staff and patients had access to a positive behavioural support lead. We saw an example of a positive behavioural support plan that had been developed with a patient. The plan had resulted in a reduction of incidents related to the individual.

Safeguarding

Staff were trained in safeguarding. Staff compliance with training at the time of our inspection was 80%. Staff knew how to protect clients from abuse and the service worked with other agencies to do so. Staff we spoke with displayed a sound knowledge of safeguarding principles and procedures. They were aware of different types of abuse and how to raise a concern. The staffing establishment included a social worker who acted as a safeguarding lead for the service. There was a safeguarding policy in place to provide further support to staff when managing and reporting safeguarding concerns. There were good links and relationships with local safeguarding bodies.

Staff access to essential information

Staff were able to access the information they needed when they needed it. All information needed to deliver patient care was available to relevant staff, including bank and agency staff when they needed it and was in an accessible form. Staff used both paper and electronic records. Paper records were stored securely in locked cabinets. Electronic records were protected by password access.

Medicines management

Staff followed good practice in medicines management. Staff transported, stored, dispensed and administered medication in line with national guidance. We reviewed ten medication files. Each file contained relevant paperwork including medication administration records which were

Long stay or rehabilitation mental health wards for working age adults

Good 

fully completed, legible and signed by appropriate individuals. Staff supported patients to self-administer medication where appropriate. There was a risk assessment and stepped process to support this.

Staff completed regular medication audits and stock checks. Issues identified were discussed with staff individually and in team meetings. Staff monitored the temperature of fridges used to store medication and responded to any discrepancies. The service contracted an external pharmacy who visited monthly and completed further audit and assurance activities.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance.

Track record on safety

The service had not reported any serious incidents within the last 12 months.

Reporting incidents and learning from when things go wrong

The service had systems in place to record and learn from when things went wrong. Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Incidents were reported via an electronic system.

Reported incidents were reviewed by a multi-disciplinary team on a weekly basis. This process was led by the psychology service. Staff received feedback following incidents. Details of lessons learnt and identified actions were shared within the weekly meeting and via email, team meetings and supervision. Staff and patients had access to debriefs following incidents where this was required.

Staff understood their responsibilities under the duty of candour. Duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have or could have potentially led to significant harm.

Are long stay or rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Good 

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. We reviewed five care records. All five records had a comprehensive assessment of patient's needs. This included information gathered as part of the referral process. Assessments covered all relevant domains and had been regularly reviewed and updated.

Occupational therapy staff assessed patients independent living skills over a 12-week period following admission.

Staff assessed patients' physical health needs in a timely manner after admission. There was ongoing monitoring of physical health needs where required throughout the patients' treatment. Staff completed required physical health checks and kept appropriate records of physical health observations. A physical health checklist was in place.

Patients and staff worked collaboratively to develop care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-orientated. They included goal setting formulated around SMART objectives. These are objectives that are specific, measurable, achievable, relevant and have a timescale for completion. Patients set both short term and long-term goals. Care plans were reviewed and updated regularly.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. These included appropriate medical prescribing and the provision of relevant psychological therapies. Patients had access to cognitive behavioural therapy, dialectical behavioural therapy and mindfulness. Staff provided one to one or group sessions around aggression and violence management, sexual offending, psychosis and anxiety. Occupational therapy provided a weekly programme of activities helping patients acquire and maintain social and living skills.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff we spoke with were able to describe referral processes into local healthcare services. Patients we spoke with discussed being supported with their physical health concerns. Records we reviewed showed patients had been supported to attend healthcare appointments and demonstrated appropriate communication with relevant physical health services.

Staff supported patients to live healthier lives. This included staff support and advice and the provision of information leaflets covering a range of physical health and lifestyle issues. A walking group was in place six days of the week. A personal trainer attended the unit weekly and offered yoga and appropriate exercise regimes. Support around smoking cessation was available.

Staff used technology to support patients. Patients had access to tablets with relaxation applications. There were two computers available for patients to use for their own purposes.

Staff used recognised rating scales to assess and record severity and outcomes. These included recovery stars, health of the nation outcome scales and the brief psychiatric rating scale. Therapy, psychology and occupational therapy staff also completed specific monitoring and outcome tools.

Staff engaged in local clinical audits. These included audits of mattresses, medication and client files.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the unit. These included on-site occupational therapy and psychology services, a cognitive behavioural therapist, a social worker, nurses and recovery workers. There was a psychiatrist who acted as responsible clinician for all patients. Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

Managers supported staff in their roles and in their development. New staff were provided with an appropriate induction. Staff had access to regular managerial and clinical supervision. At the time of our inspection compliance with supervision was 92%. Staff we spoke with told us that supervision happened regularly and was

meaningful. Staff who required additional professional supervision as part of their registration received this from either professional leads within the provider company or external individuals. Staff received annual appraisals. Compliance with annual appraisals was 100%. Staff had access to regular team meetings.

Managers supported staff to develop their skills and staff were able to access additional specialist training. Training needs were identified through assurance and governance process such as audits and incident investigations as well as through supervision and appraisal. There was access to additional specialist training including around epilepsy, positive behavioural support, autism awareness and level three qualification and credit framework courses.

Managers received support from a human resources service to manage poor performance and disciplinary procedures. There were policies and procedures to support these processes.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multi-disciplinary meetings. There were weekly multi-disciplinary patient review meetings which ensured each patient was reviewed fortnightly as a minimum. Patient family and carers were invited to patient reviews. Staff shared information about patients at effective handover meetings between shifts. These were attended by the nurse in charge of the outgoing shift and all members of the incoming shift.

Staff had effective working relationships with teams and services outside of the organisation including the local authority, safeguarding bodies, local healthcare providers and commissioners. Staff worked well with patients' local care coordinators and mental health teams where appropriate. Care coordinators were invited to attend patient reviews and care programme approach meetings. When they could not attend, notes of the meeting were sent to them. Additional contact was maintained through telephone and email.

Adherence to the MHA and the MHA Code of Practice

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. They understood their roles and responsibilities under the Act and Code of Practice and discharged these well.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff had easy access to administrative support and legal advice on implementation of the Act and the Code of Practice. There was an onsite Mental Health Act administrator and relevant leads at provider level. Staff had access to relevant policies and procedures. Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. The Mental Health Act administrator carried out regular audits of paperwork.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Patients had easy access to an independent advocacy service which visited the unit weekly and attended care review meetings.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. At a CQC Mental Health Act Review visit in August 2019 we identified that staff were not always capturing patient views following periods of leave. At this inspection we found that the Section 17 leave form had been changed to better capture patient feedback.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Good practice in applying the MCA

Staff were trained in and had a good understanding of the Mental Capacity Act and the five statutory principles. Compliance with training was 75%. Staff understood their roles and responsibilities under the Act and discharged these well. Staff had access to relevant policies and procedures. There were professional leads within the provider organisation who could provide further information and guidance.

Staff assessed capacity regularly and supported patients to make decisions wherever possible. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff worked with relevant family members, loved ones and professionals to make decisions in their best interests. We saw examples of best interest decisions that had been made. These had been completed appropriately and consideration given to the patient's wishes, feelings, culture and history.

Staff undertook audits of the application of the Mental Capacity Act and responded to any findings or recommendations. The service had made no deprivation of liberty safeguards in the six months prior to our inspection.

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

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services where appropriate and, if required, supported them to access those services.

We spoke with six patients during the inspection. Patient feedback on staff was positive. Patients considered staff to be caring, considerate and supportive. Staff interactions with patients that we observed were appropriate and respectful. Staff were responsive to patient need and we observed them providing emotional support to individuals when it was required.

Staff maintained the confidentiality of patients. There was training, policies and procedures to support staff in this regard. Staff we spoke with told us that they could raise concerns about disrespectful, discriminatory or abusive behaviours or attitudes towards patients without fear of the consequences.

Involvement in care

Staff used the admission process to inform and orient patients to the service. Patients could visit the service as part of their referral process. Patients were shown around the unit and introduced to other patients and staff. Patients were also given information leaflets as part of the referral and admission process.

Patients were empowered to take an active role in their care and treatment. Patients held weekly one to one sessions with their named nurse and were invited to attend reviews of their care and care programme approach

Long stay or rehabilitation mental health wards for working age adults

Good 

meetings. Patients were involved in the identification of their rehabilitation goals and the development of their care plans. For example, one patient had devised their own care plan around absconson and self-harm. Patients were offered copies of their care plans. Patients we spoke with were aware of their care plan and its contents. Staff communicated with patients so that they understood their care and treatment.

Patients had access to an advocacy service. The service was advertised on the unit and attended weekly. The advocacy service also attended care reviews when requested. Patients we spoke with were aware of the advocacy service. Patients who had used the service described it as a positive experience.

Patients were able to give feedback on the service. There were daily community meetings where patients could raise concerns and provide feedback. Patients completed exit surveys and an annual patient experience survey. There was a nominated patient representative from among the patient group who could also represent patient views to management. Patients sat on staff interview panels.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Family members and carers were given relevant information when their loved one was admitted. Carers were invited to attend multi-disciplinary and care programme approach meetings. Staff maintained contact with family members and carers through email, letter and phone conversations.

Carers were able to give feedback on the service via an annual survey and through a comments facility on the provider website.

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

Good 

Access and discharge

The service had documented admissions criteria. There were clear referral pathways and an admission process to ensure the suitability of admissions. Managers worked with commissioners and referring services to support patients during referral, transfer and discharge from services.

The average bed occupancy between 1 March 2019 and 31 August 2019 was 71%. The average length of stay between 1 August 2018 and 31 July 2019 was 1405 days. There was a small cohort of historic patients whose length of stay exceeded the service model. Some of these patients had had potential placements withdrawn or fall through. Staff we spoke with described difficulty in finding the right placement to meet their needs as the primary barrier to discharge. Records showed regular conversations with care coordinators and commissioners in an attempt to promote discharge. There were two patients on delayed discharge. One patient was due to visit two possible placements. The care coordinator for the second patient was identifying alternative placements after the patient had turned down a proposed placement.

Staff proactively planned discharge. This began from the point of referral. We reviewed five care records and found that each had a discharge plan in place from the point of admission. Plans had been developed with patients and detailed what discharge would look like for them and the actions required to achieve this. These were reviewed in fortnightly care reviews and within care programme approach meetings. More detailed discharge planning was completed at later stages in the treatment pathway. This was multi-disciplinary in nature including nursing, occupational therapy, psychology and the social worker care package assessments. Staff liaised with commissioners and care coordinators in relation to discharge planning and preparation.

Where a discharge placement was identified staff supported patients through the process with graduated visits and transitional leave. This enabled patients to familiarise themselves with their new environment. The service had discharged five patients in the 12 months prior to our inspection.

There was one out of area placement at the time of our inspection. Staff maintained regular contact with their local care team.

The facilities promote recovery, comfort, dignity and confidentiality

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff and patients had access to the full range of rooms and equipment to support treatment and care. These included a rehabilitation kitchen, dining room, lounge, meeting and therapy room, laundry facilities and access to outside space. Some spaces within the service were decorated by artwork produced by patients. The garden area included a small allotment, raised beds and greenhouse. However, the garden area included a secure fence that spilt the garden in two and required opening by staff. We discussed this with the service management. They acknowledged that the fence had been assessed as inappropriate and confirmed that work was underway to look at removing the fence and completing some remodelling of the garden area.

Patients had their own bedroom. Bedrooms were ensuite. Patients were able to personalise their rooms and access them during the day. Bedrooms had facilities to securely store their possessions. There was a rehabilitation flat that patients could access as part of their treatment programme to enable them to prepare to move into the community.

There was a designated visitor's room off the main ward area where patients could meet loved ones in privacy. Patients access to mobile phones was individually risk assessed. Patients had access to a choice of foods which was prepared onsite. The service was able to meet dietary requirements such as vegetarian and vegan as well as provide kosher and halal meat. Dietary needs were identified as part of the referral and admission process. Patients had access to hot drinks and snacks during the day. Patients we spoke with were positive about the food available to them.

Patients' engagement with the wider community

Staff supported patients to ensure they had access to activities outside of the service including access to education and work experience opportunities as well as leisure activities.

Staff supported patients to maintain contact with their families, carers and people that mattered to them. This was through access to mobile phones, the facilitation of visits and the provision of leave.

Patients had been supported to register and vote in the general election of December 2019.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. There were ramps into the facility and assisted bedroom and bathroom on the ground floor.

Staff helped patients with their communication needs. Information was available in different formats upon request. Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Staff were able to arrange access to translation services which included face to face, document and telephone translation.

Patients had a choice access to appropriate spiritual support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff. Information on how to complain was displayed on the unit and provided to patients and carers.

Patients we spoke with either knew how to complain or told us they would speak to staff. Patients told us that they would be confident that staff would respond to any complaint appropriately. Staff we spoke with were aware of the service's complaints policy. Lessons learnt and identified actions from complaints were shared with staff through team meetings, supervision and email.

In the 12 months prior to our inspection the service had received 12 complaints. Four of these were upheld and eight were not upheld.

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

Good 

Leadership

Managers at the service had the skills, knowledge and experience to perform their role. They had a good understanding of the service and the individual needs of patients. They could explain how the service was working to provide high quality care.

Long stay or rehabilitation mental health wards for working age adults

Good 

Managers and senior staff from the provider organisation were visible within the service and approachable for clients and staff. Staff we spoke with told us that they knew senior managers within the provider organisation.

Staff, including those below manager level had access to leadership training and development.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The vision and values were under review at the time of our inspection. Staff and patients were involved in this review. The existing vision and values were on display within the unit.

Staff had the opportunity to contribute to discussions about service development and business strategy. This occurred within team meetings, supervision, appraisal and at ad-hoc staff events. Staff we spoke with told us that managers and the provider organisation were open to new ideas to improve the service and that they were encouraged to make suggestions. Managers and staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. Staff we spoke with described a supportive culture which encouraged positive team work and collaboration. Staff worked well together as a multi-disciplinary team. Staff were positive about the work they did and proud of the care and treatment they provided.

Staff we spoke with described an open and honest culture. They felt able to raise concerns without fear of reprisal or victimisation. Staff were aware of the providers whistle blowing policy and how to use it. The provider used an external company that staff could raise concerns with if they did not want to use the internal procedure. Managers dealt with poor staff performance and disciplinary issues in an appropriate manner. Staff appraisals included conversations about carer development and identified actions to help achieve progress.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for carer progression. Staff had access to support for their own physical and emotional health needs through an occupational health service.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively, and that performance and risk were managed well. There was a governance structure in place at unit level. This fed into the providers governance structure and shared learning forums.

There was a clear framework of what was to be discussed in team meetings to ensure that essential information, such as learning from incidents and complaints were shared and discussed. Performance was monitored at both unit and provider level. Managers met quarterly with commissioners to discuss performance and review patients.

There were systems and procedures to ensure that the unit was clean and safe, and that equipment was suitable for use. Staff held a weekly meeting to review and share learning around adverse incidents including any use of restraint.

Staff undertook audits, visits and mock inspections to monitor service quality and compliance. This included a programme of visits by an independent group of 'lay visitors.' Staff had implemented recommendations from incidents, complaints and assurance processes. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of patients.

Management of risk, issues and performance

Staff maintained and had access to a risk register at unit level. This was reviewed quarterly and fed into the providers risk register. Staff we spoke with were able to discuss items on the risk register and felt able to escalate concerns when required.

The service had business continuity plans in place for emergencies such as adverse weather. These laid out how the service would continue to deliver care and treatment under such circumstances.

Managers reviewed changes to the service to ensure they did not compromise patient care. This included working with patients and provider level services such as the finance and quality teams.

Information management

The service used systems to collect data that were not over-burdensome to staff. Staff had access to the

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equipment and information technology they needed to do their work. Staff we spoke with told us that the information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, accurate and used to identify areas for improvement. Information systems protected the confidentiality of patient records.

Staff made notifications to external bodies as required.

Engagement

Staff, patients and carers had access to up to date information about the work of the service through team meetings, the internet, notice boards, newsletters, leaflets and social media platforms. Staff were able to give feedback on the service and provider through an annual staff survey as well as in supervision and appraisal meetings.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients had access to a daily community

meeting and well as completing patient experience surveys. Results from the most recent patient survey (July 2019) were positive. Patients also nominated a patient representative who could raise concerns.

Patients and carers were involved in decision making about the service. For example, patients could sit on interview panels for staff and were contributing to the review of the provider and services vision and values.

Managers engaged with external organisations such as local commissioners, healthcare services and the CQC. There were effective partnerships with local safeguarding bodies, support services and the local recovery network.

Learning, continuous improvement and innovation

The service was committed to improving care and treatment from learning when things went well or went wrong. Staff were given the time and support to consider opportunities for improvements and innovation.

The service made efforts to gain feedback from staff, patients, families and partner agencies to improve the quality of treatment provided. The service developed and monitored action plans in response to incidents, complaints and assurance processes.