Elysium Healthcare Limited

Bromley Road Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service provided safe care. The ward environments were safe and clean and staff managed environmental risks well. The wards had enough nurses. The service had successfully over-recruited to its nurse vacancies. 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. This included psychology and occupational therapy support aimed at developing patients daily living skills. 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. As a result, discharge was rarely delayed for anything other than a clinical reason.
- 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.

However:

- Although the service was working to embed a more robust approach to out of hours medical cover, there was a present risk that the substantive consultant psychiatrist might be difficult to get hold of whilst they were off work.
- Staff had been recording routine physical health checks on two separate records, and there were delays to some patients' annual physical health checks (required because they were prescribed high-dose antipsychotic medicines). These issues had not been identified by the provider's internal governance systems.
- The service did not currently have a registered nurse lead for physical health. Although a nursing assistant did hold this role, staff needed to be supported appropriately to manage and monitor patients' physical healthcare needs, which, we noted, were significant.

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	

Summary of findings

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Summary of this inspection

Background to Bromley Road Hospital

Bromley Road Hospital is a complex care, high dependency rehabilitation service. This means that patients typically present with severe symptoms of mental ill health and often other health conditions and are usually detained under the Mental Health Act 1983. The service is provided by Elysium Healthcare Limited and aims to prepare patients for discharge to the community or supported living services. This is achieved through assessment, engagement, maximising benefits from medicines, reducing distressed behaviours and re-engaging with families and communities. There are two main pathways at the service: treatment engaging, with a typical length of stay of 6-12 months, and treatment resistant, with a typical length of stay of 12-18 months. Olive ward had 18 beds. Cedar ward was now a small 6 bed step-down ward where patients were being prepared for discharge to the community. Staff worked across the entire hospital rather than on designated wards.

The service is in Catford, south London. Patients can aim to integrate into the local community by joining community projects including peer support projects, recovery colleges, music programmes, art networks and volunteer work programmes.

The service was last inspected in November 2018 and was rated in good across all five key questions and good overall.

How we carried out this inspection

During the inspection, we conducted two Short Observational Framework for Inspection (SOFI). SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services.

During the inspection we also:

- spoke with 5 patients
- spoke with 11 staff, including nurses, a doctor, nursing assistants, a psychologist, an occupational therapy assistant, 3 senior leaders and a regional user involvement lead
- reviewed 5 patient care and treatment records
- reviewed 9 patient medicine records
- conducted a detailed tour of the physical environment
- reviewed a range of other documentation relating to the running of the service

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

Areas for improvement

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

Action the service SHOULD take to improve:

Summary of this inspection

- The provider should ensure patients who receive high-dose antipsychotic medicines receive a physical health check every 12 months.
- The provider should ensure staff use one system consistently to monitor patients' physical health to minimise the risk that anomalies might not be escalated promptly.
- The provider should consider whether a more senior physical health lead is necessary to hold staff to account on how they monitor and manage the physical health of patients.
- The provider should continue with its plans to formalise out of hours medical cover arrangements.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good

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

Is the service safe?

Good

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

Safe and clean care environments

All wards were safely managed, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The hospital building was converted from existing town houses and was not purpose built. Therefore, there were numerous environmental risks that staff carefully managed, such as complex ward layouts resulting in blind spots that needed to be checked by staff regularly.

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

Whilst the service was working towards being female only, there were currently two male patients on cedar ward. Patients had access to separate bathroom facilities and private spaces.

During the last inspection in November 2018, we identified that ligature risk assessments did not contain the necessary detail about control measures that staff should put in place to minimise the risk of potential ligature points to patients. A ligature anchor point is anything that could be used to attach a cord or other material for the purpose of hanging or strangulation. At this inspection detail was provided to staff about how to safely manage identified ligature risks, and this was also discussed as part of the staff induction.

Although there were numerous blind spots and potential ligature anchor points on both wards, staff knew where these risks were and conducted rigorous observations to manage the risk they posed to patients. Patient risk histories were carefully considered when assessing whether potential admissions were suitable for the service because of the environmental risks.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Long stay or rehabilitation mental health wards for working age adults

Good

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Staff made sure cleaning records were up-to-date.

Staff followed infection control policy, including handwashing. A recent external infection prevention and control inspector had visited because the service was working towards complying with the 'NHS safe room' standard of cleanliness. Bromley Road Hospital was the first of the provider's locations to work towards meeting this standard.

Clinic room and equipment

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

Staff checked, maintained and cleaned equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe; and had recruited to all nurse and nursing assistant posts. The service had also recruited additional permanent staff to protect against the risk of staff shortages should staff resign in the near future. For example, the registered nurse establishment was 11.7 whole-time equivalent (WTE) but there were currently 12.8 WTE registered nurses in post. This meant that the service did not rely on excessive use of agency staff or staff working bank shifts. This meant that staff working with patients were consistent and knew the individual needs of patients and were able to develop meaningful therapeutic relationships with them.

Between May and November 2023, ten staff had left their posts, and eleven staff had been recruited during the same timeframe. Staff sickness was also low, and averaged between 1.7% and 2.6% between June and September 2023.

All new staff completed a two-week induction, which had recently been reviewed and strengthened by the provider. Staff reported that this induction was thorough and equipped them appropriately for their roles.

Managers reviewed staffing levels for each shift in line with patient need. If additional staff were needed, for example, to facilitate patient escorted leave, additional activities or enhanced patient supportive observations, they could recruit more staff to work as needed.

There were enough staff on each shift. Patients explained that they knew who their key worker was, that leave and activities were always facilitated as planned. Staff felt that there were enough of them on each shift to safely carry out physical interventions if these were needed.

Medical staff

One permanent consultant psychiatrist was in post whow orked two days per week, but was available on-call the remaining time. There was also a locum associate specialist doctor who worked three days per week, and the service was working to recruit a permanent consultant psychiatrist to this post.

Long stay or rehabilitation mental health wards for working age adults

Good

The permanent full time consultant psychiatrist readily made themselves available out of hours and during their annual leave to support staff if needed. The service was working to embed a more formal approach to out of hours medical cover involving doctors working at other hospitals within the provider's regional area.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All training areas had compliance rates above the provider's target of 90%.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

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 distressed behaviour. As a result, they used restraint very rarely, and only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission. These were then reviewed at regular intervals by the multidisciplinary team. Staff also updated risk assessments after any change in risk, including after incidents.

Management of patient risk

Staff knew each patient well and understood each individual patient's risks and how best to manage these. Staff generally responded to changes in risks posed by patients, such as risks of self-harm or aggression. However, we identified that one patient on Cedar ward had recently experienced a fall. Staff had not completed a post-falls risk assessment, to help minimise the risk of a further fall. When we escalated this to senior leaders a post falls risk assessment was completed.

Staff followed procedures to mitigate risks presented by the ward environments. For example, staff knew where potential blind spots in bedroom corridors were and checked these areas regularly. Senior leaders explained that historic risk of self-harm and suicide were considered very carefully when deciding whether a patient could be safely accepted for treatment at the service because of some of the environmental risks that existed.

Staff constantly assessed the restrictions that patients experienced and re-assessed whether these were appropriate. Patients and their bedrooms were only searched if there was a particular reason to suspect that a dangerous item may be being concealed. This was appropriate because it meant that patients were restricted as little as possible. Patients joined staff in regular discussions about whether there was reasonable justification for any blanket rules that were in place. For example, patients had been part of a recent discussion about de-activating the child lock on cars used by staff to transport patients in favour of this measure being risk assessed for each individual patient.

Although some patients prescribed high-dose antipsychotic medicines had not had the required physical health checks completed in a timely manner, other general physical health checks were completed appropriately for patients. Patients who were prescribed clozapine received the necessary blood monitoring to mitigate the risk of neutropenia, which is a reduction in white blood cells that can affect a person's immune response.

Long stay or rehabilitation mental health wards for working age adults

Good

Use of restrictive interventions

Staff spoke about the importance of using verbal de-escalation techniques and using individual patient positive behavioural support plans to manage distressed behaviours. This meant that incidents were de-escalated, and there were no recent incidents of restraint. Staff were trained in safe restraint techniques but would only use these techniques as a last resort if their verbal de-escalation efforts had not worked.

There were no recent incidents resulting in rapid tranquilisation and there had been no recent episodes of seclusion. There were no seclusion facilities on site.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

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

Staff followed clear procedures to keep children visiting the ward safe. Work was currently being undertaken to improve a visiting room away from the main ward areas where children could visit.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. Patient records were mostly electronic. All staff had easy access to records and kept them up-to-date.

All records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff reviewed the effects of medications on each patient's mental health, but did not always conduct prompt physical health reviews for patients prescribed high-dose antipsychotic medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

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

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. There were not currently any controlled drugs stored on site. Staff kept both controlled-drug cupboard keys together, but were alert to the need for these keys to be separated if the controlled drugs cupboard needed to be used.

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

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

We identified that some patients who were prescribed high-dose antipsychotic medicines had not received a detailed physical health check within the required 12-month period. Patients prescribed high-dose antipsychotic medicines are at increased risk of developing physical health problems, so need close monitoring. We escalated this finding on site and staff promptly took action to arrange physical health checks for patients who had not received these within the 12-month timescale.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Incidents were investigated thoroughly and learning points were shared with all staff at team meetings. Staff also learnt from incidents that had happened elsewhere at the provider's other services. Staff had recently discussed incidents of racially aggravated abuse aimed at staff members. Psychology staff had been involved in supporting staff with a debrief and staff had met to discuss how to correctly identify hate crime incidents and report these to the police.

Although incidents were managed appropriately, reviewed, and discussed by staff, there was not yet a systematic local review of incident themes and trends.

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

Is the service effective?

Good

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

Long stay or rehabilitation mental health wards for working age adults

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Senior staff explained that they were alert to the need to very carefully consider patients risk histories when considering whether patients could safely be accepted for treatment at the service. Decisions to admit new patients always involved the consultant psychiatrist, who was clear about the types of patients whose needs the service would not be able to safely meet. This included patients with risk histories including significant self-harm or suicide attempts, because of the risks posed by the environment should the patients mental health deteriorate after admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. Patients were supported to lead a healthy lifestyle, and the physical health lead and psychologist supported patients with healthy eating and weight management. A dietician also worked closely with some patients to develop meal plans to support them to lead a healthy lifestyle. The psychologist ran specific groups around maintaining good mental wellbeing, addressing substance misuse and how to offer peer support.

Staff made sure patients had access to physical health care, including specialists as required. All patients were registered with a local General Practitioner, who they could access with ease.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the psychology team used outcome measures to assess changes in anxiety and depression symptoms. They also monitored the development of individual intrapersonal skills.

Since the last inspection in November 2018, the provider had changed the patient pathway. At this inspection, only two male patients remained on Cedar ward and the hospital was in the process of becoming female only. Cedar ward was now a small step-down ward, focussed on preparing patients for discharge to the community. For example, self-catering facilities were almost ready for use at the time of the inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

There were two main pathways at the service: treatment engaging, with a typical length of stay of 6-12 months, and treatment resistant, with a typical length of stay of 12-18 months. The individual patient's pathway determined the type of psychological and occupational therapy support they received to support their recovery.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

All staff attended reflective practice sessions twice per month, where they discussed professional elements of their practice.

Managers gave each new member of staff a full induction to the service before they started work. If temporary staff were required, they received an induction and orientation at the start of their shift.

Staff received regular monthly supervision and attended annual appraisals. During the last inspection in November 2018, we identified that staff supervision records were not detailed. At this inspection information about staff wellbeing, training needs and career aspirations was clearly recorded.

The occupational therapist post was vacant at the time of the inspection. A temporary locum occupational therapist was currently working at the service and occupational therapy assistants were experienced and knew the patients well.

A permanent clinical psychologist worked at the hospital and was supported by two psychology assistants.

Although a physical health lead was in place, this role was fulfilled by a nursing assistant rather than a more senior registered nurse. Many patients requiring treatment at this type of service live with complex physical health conditions or require rigorous routine physical health monitoring to detect potential physical health deterioration caused by their mental health medicines. The lack of a senior, appropriately trained physical health lead posed a potential risk that staff might not receive the support they needed to feel confident to correctly manage patient's physical health.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

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

Staff worked closely with physical health specialists where patients were receiving specialist support for physical health conditions. They also liaised closely with other mental health teams around admission and in supporting patients to prepare for discharge from the service.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All patients were detained under the Mental Health Act at the time of this inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support.

The Mental Health Act administrator carried out audits of detention paperwork. The administrator also ensured patients attended hospital managers' hearings and MHA tribunals, and that the necessary professionals, including commissioners, were invited to Care Programme Approach meetings where a patient's care was reviewed.

Copies of patients' detention papers and associated records were stored securely, and staff could access them when needed.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

Staff authorised and administered medicines for detained patients in line with the MHA code of practice. For example, we noted that patients' consent to treatment forms were completed accurately and kept with their medication charts for staff to easily access.

Good practice in applying the Mental Capacity Act

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.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discrete, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. Patients were encouraged to participate in discussions about their care, for example, during ward round meetings.

There was a cohesive culture, where patients expressed that they had very positive relationships with staff and other patients. We observed specific and tailored interactions between staff and patients which met each patients' individual needs. Staff knew patients very well and specific details about how best to communicate with patients were included in individual patient care and treatment records.

Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient and worked hard to meet these needs and preferences, such as dietary needs. Staff directed patients to other services and supported them to access those services if they needed help.

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

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff involved patients and involved them in developing their care plans and individual risk management plans. The regional audit lead had recently completed a care plan evaluation to help ensure nursing staff and patients had collaborated appropriately to develop care plans.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients met each day with staff to discuss the plan for the day and met weekly for a more formal community meeting where their feedback and suggestions were encouraged.

During the last inspection in November 2018, we identified that actions identified at community meetings were not always recorded and patients did not always receive feedback on actions staff had taken to address their concerns. During this inspection, we observed that community meetings between staff and patients were minuted and updates on actions were displayed on notice boards for patients to refer to.

Patients were able to provide feedback about the service. For example, patients had fed back that they felt rushed during MDT ward rounds, and that they therefore didn't feel confident to contribute. Staff worked with patients and their relatives to design an agreed meeting structure that facilitated patient and family member contribution to discussions.

A service user by experience worked regularly at the service and spent their remaining time attending the provider's other services. Their sole focus was in ensuring the patient voice was embedded into all policies and procedures and that patients could contribute meaningfully to discussions about the running of the service. They attended monthly patient council meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Where patients had consented, family members were invited to attend ward rounds and to contribute to discussions about their loved one's care and treatment options.

Psychology staff had a future ambition to develop the offer of family therapies, which were only currently available to families on request.

Families and carers were encouraged to provide feedback about the service.

Is the service responsive?

Good

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

Long stay or rehabilitation mental health wards for working age adults

Good

Access and discharge

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

At the time of the inspection, there were 14 patients on Olive ward and 4 empty beds. Cedar ward, which was the step-down ward where patients were preparing for discharge to the community, had 5 patients and one empty bed. Patients were regularly reviewed to help ensure they didn't stay at the service longer than they needed to. Discharge plans were developed from the start of the patients stay to help prevent delays when patients had completed their treatment and were ready to move on.

Senior staff including the consultant psychiatrist were clear on the types of patient who could and could not safely be treated at the service. For example, the service was not geared up to provide treatment to people with a primary diagnosis of significant emotionally unstable personality disorder, acquired brain injuries or organic mental health disorders such as dementia. Instead, these referrals were signposted to other services that were better suited to meeting these patients needs.

There were two main pathways at the service: treatment engaging, with a typical length of stay of 6-12 months, and treatment resistant, with a typical length of stay of 12-18 months.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. There was one patient whose length of stay exceeded the maximum 18-month target. Leaders had carried out the appropriate escalation process and were discussing discharge plans with care coordinators and colleagues at the local Integrated Care Board to help identify a more suitable placement for the patient.

Discharge started to be planned at the point of admission. When the funding authority had identified an onward placement for a patient to be discharged to, routine discharge planning meetings were scheduled which involved family members and care coordinators. Transition events such as overnight leave to the target discharge placement usually formed part of discharge planning.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and access to shared bathroom facilities and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater on cedar ward.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

Patients could make phone calls in private using either their own mobile telephones if they had access to them, or using the ward telephone.

The service had gardens to the back of the building that could be readily accessed by patients.

Long stay or rehabilitation mental health wards for working age adults

Good

During the last inspection in November 2018, we identified that the provider needed to complete its programme of refurbishment works. At this inspection, improvements had been made to the environment. Most of the works had been completed, but there were still plans to fix leaks to the conservatory roof on Olive ward and to improve the visitors room at the front of the hospital.

There were also plans to build additional garden sheds to provide more activity spaces. Final improvements were also being made to the cedar ward kitchen, which was almost ready for patients to start self-catering.

Patients consistently reported that the food was of particularly high quality. Patients contributed to discussions about what meals they would like to feature on the menu. Patients could easily access drinks and snacks at any time.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships, which was important for their rehabilitation and re-integration into the community.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients frequently attended local gyms, hairdressers and cafes. Some patients did voluntary shifts at local charity shops to help prepare them for future employment.

Patients accessed a recovery college that was provider by the local NHS mental health trust. This enabled them to access groups where they learned computer skills, cooking, English skills and could gain recognised qualifications in these areas, which in turn helped their future employment prospects.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Although Olive ward was upstairs, it could be accessed by a lift.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Any information could be translated for patients into a language they understood. If needed, interpreters could be booked to attend meetings. Managers also made sure staff and patients could get help from interpreters or signers when needed.

During the last inspection in November 2018, we identified that the service could do better at identifying and meeting the holistic needs of patients, particularly in relation to sexuality and cultural needs. At this inspection we identified that staff understood the unique needs of individual patients. For example, staff spoke about supporting patients with their religious needs and to access worship opportunities. They also spoke about supporting patients with gender transition.

Listening to and learning from concerns and complaints

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

Long stay or rehabilitation mental health wards for working age adults

Good

Patients, relatives and carers knew how to complain or raise concerns and information about how to follow the provider's complaints policy was available on the wards and on the provider's website.

Staff understood the policy on complaints and knew how to handle them. Complaints had to be acknowledged within 5 days and resolved within 20 days. All recent complaints had been handled within these targets.

Complaints were investigated and learning identified. The learning was then discussed by staff during routine staff meetings.

Is the service well-led?

Good

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

Leadership

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

Leadership development opportunities were available to staff. Senior nurses were being supported to take on stretch tasks to prepare them for the next step in their career. For example, some nurses had been given responsibility for providing senior level clinical updates and completing reports for commissioners.

Vision and strategy

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

Staff knew about the provider's set of values and demonstrated these in their day to day work. The values were kindness, integrity, teamwork and excellence. Senior leaders had successfully communicated these values to frontline staff.

Culture

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

Staff reported feeling proud to work for the provider and that they enjoyed their roles and felt respected at work. We observed numerous interactions between staff and between staff and patients that were compassionate and tailored to the individual being communicated with.

Staff reported feeling able to raise concerns without fear of retribution. They explained that staff had worked on fostering a culture of psychological safety, where anything could be fed back, and it would be listened to by leaders.

Leaders explained how they supported staff to improve following incidents of poor performance. Good practice and positive performance was recognised. A star of the month award scheme was in place. This involved multiple staff being

nominated for a £50 award each month across the organisation, and numerous staff at the service had won this award in previous months. Staff also received letters of reignition for good performance. A staff benefits scheme was also in place and a community box was in operation, where staff donated food items and others were welcome to help themselves.

Staff had access to support for their own physical and mental wellbeing. An occupational health service was used for pre-employment screening and any staff sickness support. Staff could also call a wellbeing helpline at any time.

A staff survey had recently been completed and the service was currently developing an action plan to be issued in early 2024. The key areas for improvement highlighted in the staff survey were staff feeling burnt out and feeling that their pay could be improved.

Governance

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

There was a clear framework of what must be discussed at a team level in team meetings. All staff met together monthly for a staff meeting, where they discussed recent incidents and complaints. However, although incidents were discussed as needed and learning was identified to help prevent them re-occurring, themes and trends in incident data were not routinely reviewed. We were told this is something that senior leaders planned to embed in the near future, as the omission posed a risk that anomalies or changes in incident frequency might go undetected.

Heads of each discipline also attended monthly clinical governance meetings with the hospital director and two patients. The hospital director attended a monthly regional governance meeting, which leaders who worked in at the provider's other services within the region attended. This enabled learning to be shared across services.

Staff completed local clinical audits. However, the audit system had not identified that staff had been recording routine physical health monitoring on two separate record types. This had posed a risk that physical health anomalies may not be easily detected because monitoring was recorded on duplicate systems.

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

Management of risk, issues and performance

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

A service-level risk register was in place and leaders had a good understanding of what the key risks to the service were. The key risks, including the physical environment, staffing levels, financial viability (related to bed occupancy) and the risk of developing a closed culture, were well understood by staff and were routinely discussed and actions agreed to mitigate the risk of these issues becoming problematic.

Leaders had dashboard with gave them access to key information such as staffing levels and training compliance. However, supervision and appraisal compliance was not yet showing on this dashboard, and was instead being monitored using a spreadsheet. There had also not been an effective system in place to alert staff to the need to complete physical health reviews for patients prescribed high-dose antipsychotic medicines in a timely manner.

Long stay or rehabilitation mental health wards for working age adults

Good

Information management

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

Appropriate information technology systems were in place to support staff to carry out their work. Data was collected using these systems in a way that was not too burdensome for staff.

Confidentiality of patient information was maintained and the information systems that were being used supported staff to maintain confidentiality relatively easily.

Managers had access to an electronic dashboard which gave them key information, such as staffing information, to help them manage the service and its performance. Management information was in an accessible format.

Staff made referrals to external bodies when necessary, such as the local authority safeguarding adults team if there had been allegations of potential abuse within the service.

Engagement

Managers engaged actively other local health and social care providers, particularly the local NHS mental health trust, to ensure that an integrated approach to health and care was achieved.

The service was developing its approach to carer involvement. Feedback was actively sought from patients and their families and acted on. Relatives and carers could keep up to date with developments at the service via the website and routine newsletters.

Patients contributed to discussions about the running of the service. Two patient representatives attended the monthly clinical governance meeting and a service user by experience regularly attended the service to speak with patients, gather their views and contribute to discussions about the running of the service.

Learning, continuous improvement and innovation

The service had started working towards meeting the required standard to be accredited by the Royal College of Psychiatrists Standards for Inpatient Mental Health Rehabilitation Services in the near future.