CareQuality Commission

Priory Healthcare Limited

The Priory Hospital Southampton

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 improved. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They conducted emergency scenario simulations to ensure that staff became accustomed to responding to unexpected events. 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 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.
- The service managed beds well.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- The hospital used a high number of agency staff.
- Patients and staff raised concerns over the competency of new agency staff working on an eating disorder ward.
- Nurses did not complete the safety checks consistently on Skylark ward.
- Not all staff knew where both ligature cutters were located on Skylark ward. Not all staff knew where the potential ligature points were around the ward.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good ●	Our rating of this service improved. We rated it as good because: • The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. 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 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. • The service managed beds well. The hospital had arrangements local NHS to ensure that admissions and discharges were managed well. • The service was well-led. The governance processes ensured that ward procedures ran smoothly. However: • The hospital used a high number of agency staff.

Summary of findings

Specialist eating disorder services

Good ●

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

- The ward was 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.
- 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 regular supervisions and appraisals. The ward staff worked well together as a multidisciplinary team with the wider hospital teams.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, relatives and carers in care and treatment decisions.
- 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, and had direct views from patients.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Patients had access to CBT-E, DBT, MANTRA and patients could access additional therapies, such as dramatherapy, body image therapy and developing identity therapy.
- Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005. Patient records showed that staff assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- The service managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Staff worked closely with local authorities and community eating disorder teams.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of

Summary of findings

the services they managed, and were visible in the service and approachable for patients and staff. The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Patients and staff raised concerns over the competencies of new agency staff working on an eating disorder ward.
- Nurses did not complete the safety checks consistently on Skylark ward.
- Not all staff knew where both ligature cutters were located on the ward and not all staff knew where the potential ligature points were around the ward.

Summary of findings

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Summary of this inspection

Background to The Priory Hospital Southampton

This was an unannounced, comprehensive inspection of the Priory Hospital Southampton. We inspected this hospital to ensure that it had made improvements identified during our inspection in August 2022.

The Priory Hospital Southampton has three wards. Sandpiper and Starling wards provide care and treatment for patients experiencing an acute episode of mental illness. Sandpiper ward can accommodate up to 17 patients. Starling ward is smaller, with 12 bedrooms. Skylark ward provides care and treatment for up to 11 patients with eating disorders. All wards admitted both male and female patients.

The hospital provides the following regulated activities:

- Treatment of disease, disorder and injury
- Assessment and treatment for persons detained under the Mental Health Act 1983

Following the last inspection in August 2022, we told the hospital it needed to make improvements to comply with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included improvements to ensure compliance with regulations relating to safe care and treatment, premises and equipment, good governance and staffing. During this inspection, we found that the hospital had made these improvements and was now compliant with these regulations.

The service has a registered manager.

What people who use the service say

Patients said that staff were kind and very supportive. They said staff treated them well and it was easy to talk to them. They felt reassured that staff spent time with all patients, getting to know them. Patients said staff were professional, they understood the triggers that caused patients to become agitated and always noticed any changes in patients' moods.

How we carried out this inspection

During this inspection, we carried out the following activities:

Acute services for adults of working age:

- We visited all the wards and conducted an inspection of the ward environments.
- We spoke with 3 ward managers.
- We spoke with 26 other ward staff including registered nurses, healthcare assistants, occupational therapists, a dietician, social worker, work coordinator and counselling psychologist.
- We spoke with 14 patients.
- We reviewed 14 patients' records.
- We spoke with senior staff including the hospital director, therapy manager and designated safeguarding lead.
- We attended meetings and activities including a handover meeting, ward round and occupational therapy group.
- We reviewed documents and policies relating to the running of the service.

Summary of this inspection

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.

Outstanding practice

We found the following outstanding practice:

- The hospital had introduced monthly emergency scenario simulations to ensure that staff became accustomed to responding to unexpected events and knew what to do in emergency situations. Staff held debriefing sessions after each exercise to look at what could be learned. These findings were reported to clinical governance meeting. Simulation scenarios had included a cardiac arrest, a patient missing in the grounds, a loss of power and a suspected poisoning.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that the appropriate nurse safety checks are completed.
- The service should assure themselves that new agency staff have the correct competencies to work on an eating disorders ward.
- The service should ensure that all staff are aware of where both ligature cutters are located on the ward.
- The service should consider including all ward activities on the timetable for patients.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Specialist eating disorder services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good ●

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

Is the service safe?

Good ●

Our rating of safe improved. We rated it as good.

Safe and clean care environments
All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout
Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. The nurse in charge of each shift completed a safety check of the ward. Overall, there was a calm atmosphere on the wards throughout our visits.

Staff could observe patients in all parts of the wards. On Sandpiper ward, an open plan nurses' area in the middle of the ward allowed staff to see along the two main corridors and a central communal area. On Starling ward, convex mirrors were used to improve visibility on corridors and bedrooms. Closed-circuit television had been installed in all communal areas.

The ward complied with guidance on mixed sex accommodation. Both wards admitted both male and female patients. Usually, there were more female patients. All bedrooms had ensuite facilities. This meant that female patients did not have to walk past the bedrooms of male patients to use a bathroom. Whilst there were no specifically designated areas for male or female bedrooms, staff assigned male patients to bedrooms in one area of a bedroom corridor. Both wards had a lounge area designated for female patients only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. On Starling ward, all bedrooms were fitted with anti-ligature features. On Sandpiper ward, bedrooms had different levels of anti-ligature features. Eleven bedrooms were designated as standard rooms, assigned to low-risk patients preparing for discharge. Four bedrooms were designated as safer rooms. These rooms had vinyl flooring, sealed windows and anti-ligature features in the bathrooms. Two bedrooms had anti-ligature features throughout, an encased television, wardrobes with shelving only and a bed that was fixed to the wall.

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

Good ●

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff said they carried an alarm. They said the alarm was tested each time it was issued to them. Alarms and call buttons were installed in patients' bedrooms and communal areas.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. There was sufficient furniture on the ward. This furniture was in good condition.

Staff made sure cleaning records were up-to-date and the premises were clean. The wards were clean and tidy. Ward housekeepers kept cleaning records. These records were up-to-date and checked by the head housekeeper.

Staff followed infection control policy, including handwashing. Wards completed a comprehensive infection control audit every 3 months. Each audit included a check of 62 aspects of infection control including the overall impressions of the state of the ward, storage of cleaning products and equipment and evidence that waste had been disposed of correctly. Each audit was used to calculate an overall score for the ward. Sandpiper and Starling ward both had an overall score of 95%. Hand washing audits were completed every three months.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic rooms had an examination couch, electrocardiogram machine, scales for weighing patients and blood pressure monitors. Staff regularly checked a defibrillator, emergency bag and oxygen cylinder. Emergency drugs were stored and checked by the pharmacist.

Staff checked, maintained, and cleaned equipment. All equipment was labelled to show when it was due to be checked and calibrated. None of the checks were overdue.

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. Sandpiper ward admitted up to 17 patients. During the day, 2 registered nurses and three healthcare assistants were assigned to the ward. This reduced to 2 registered nurses and 2 healthcare assistants at night. Starling ward was smaller, admitting up to 12 patients. Starling ward was assigned 2 registered nurses and 2 healthcare assistants during the day, reducing to 1 registered nurse and 2 healthcare assistants at night. Staff and managers said that these staffing allocations were sufficient to meet the needs of patients. All staff said they felt safe. All patients on Sandpiper, and most patients on Starling, said they felt safe on the wards.

The service had low vacancy rates. Sandpiper ward had one vacancy for a registered nurse and 2 vacancies for healthcare assistants. This amounted to an overall vacancy rate of 16%. Starling ward had one vacancy for a registered nurse and 1.7 whole time equivalent vacancies for healthcare assistants. This amounted to an overall vacancy rate of 19%. The service was recruiting to vacant posts and new staff were scheduled to start in some of the vacant post shortly after the inspection.

The service had high rates of bank and agency nurses. On Sandpiper ward, bank and agency staff filled, on average, 30% of nursing hours between November 2022 and April 2023. This varied between 37% in February 2023 to 17% in April

Good 🟢

2023. On Starling ward, the average use of bank and agency use was higher at 36%, although there had been a steady decline from 52% in November 2022 to 31% in April 2023. Of the total bank and agency use, approximately half these shifts were filled at short notice, although the monthly figures for this varied considerably. Some staff said there was still a reliance on agency staff. We discussed this with hospital managers. They explained that they were keen to reduce the use of agency staff through initiatives such as over-recruiting staff numbers and encouraging permanent staff to work additional hours. They felt that agency staff were likely to always form part of the staffing, particularly to cover short-notice absence and enhanced observations, although they felt confident that the leadership and oversight of shifts would remain with experienced, permanent staff.

Managers requested bank and agency staff familiar with the service. When managers used agency staff, they requested people who were familiar with the service in the first instance. The hospital offered considerable incentives to permanent staff to work additional shifts in order to reduce the use of agency staff. However, this initiative had yet to make a significant impact. The proportion of shifts covered by staff working overtime varied between 7% and 13% each month.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included an orientation to the ward, fire safety, patient safety and writing notes. Agency staff completed a competency checklist on carrying out patient observations.

The service had high turnover rates. Between April 2022 and April 2023, 40 staff out of a total of 109 had left the service, giving an annual turnover rate of 37%. This includes 19 housekeeping and catering staff whose roles were outsourced to other companies. Staff commented that a lot of staff had left during that time and there had been considerable change at the hospital.

Levels of sickness were low. The overall sickness rate for the hospital was 3.4%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staff said that the number of staff assigned to each shift were sufficient to meet the needs of patients.

The ward manager could adjust staffing levels according to the needs of the patients. For example, during the week before the inspection, the ward manager on Sandpiper had offered overtime to staff and used additional agency staff due to high levels of acuity on the wards. Managers could assign extra staff to work from 9am to 5pm to cover during staff training events.

Patients had regular one to one sessions with their named nurse. Patients said they were always able to speak to a nurse.

Patients rarely had their escorted leave or activities cancelled. Staff actively encouraged patients to take leave in the grounds of the hospital and engage in activities. There were sufficient staff to facilitate these activities.

The service had enough staff on each shift to carry out any physical interventions safely. Staff said that physical interventions were planned. If an emergency intervention was needed, they received assistance from staff on other wards.

Staff shared key information to keep patients safe when handing over their care to others. For example, staff worked collaboratively with other agencies when discharging patients.

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

Good 🟢

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. A consultant psychiatrist and a ward doctor worked on each ward during the week. Outside office hours, a duty doctor was available onsite. This doctor was supported through an on-call rota of consultants.

Managers could call locums when they needed additional medical cover. A locum doctor was working on Sandpiper ward.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The compliance rate for mandatory training on Sandpiper ward was 85%. On Starling ward, the compliance rate was 95%. None of the courses had a compliance rate below 75%.

The mandatory training programme was comprehensive and met the needs of patients and staff. The hospital provided a programme of 18 training courses that some or all the staff were required to complete. This included courses on basic life support, infection control, health and safety, restrictive interventions and safeguarding.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers received information each month showing the number of staff who had completed each training programme, the number of staff whose compliance with the training requirement would shortly expire and the number of staff who had not completed the training.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. A consultant psychiatrist and ward manager assessed each referral made to the service. On Sandpiper ward, the service did not accept patients with a recent history violence or aggression, a history of sexually inappropriate behaviour, a primary diagnosis of learning disability, significant mobility impairments or patients presenting a high risk of self-harm. The service also sought to limit the number of patients presenting with unpredictable self-harming behaviours. On the 14-15 April 2023, Sandpiper ward rejected six referrals made on a 'spot-purchase' basis due to the patients being referred presenting a high risk of self-harm or a recent history of suicide attempts. A local NHS trust had a block booking of 8 beds on Sandpiper ward. When patients were referred from this trust, staff were able to view the patient's medical records in order to conduct a more comprehensive risk assessment. When patients arrived on the ward, they received a comprehensive assessment from a doctor and a nurse within one hour. This included an assessment of both current and historic risks. New patients were placed on enhanced, one-to-one observations until they had been seen by a doctor. Further observation levels were agreed following this assessment based on the level of risk. Patients' risk assessments were updated throughout their admission. For example, the risk assessment for one patient had been updated on 5 occasions in their first month of admission.

Staff used a recognised risk assessment tool. Staff used a standard risk assessment tool on the electronic patient record.

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

Good ●

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Following the initial assessment, staff took immediate steps to reduce risks. For example, patients presenting higher risks were placed on enhanced observations. The nurse in charge of each shift checked that all observations had been carried out and recorded correctly. On Sandpiper ward, higher risk patients were placed in bedrooms with enhanced anti-ligature features, such as having a television encased in a wall unit and bed attached to the floor. Staff could also remove high risk items from patients, such as chargers for mobile telephones, aerosols and perfume bottles. Staff completed a 5-point risk assessment of each patient, including an assessment of their mental state, before they went on leave or participated in activities outside the hospital.

Staff identified and responded to any changes in risks to, or posed by, patients. Patients' risks were identified during the initial assessment and recorded on a risk assessment tool. The staff teams, including doctors, nurses, healthcare assistants and therapists reviewed patients each day at a safety huddle. At these meetings, observation levels were reviewed and were increased or reduced as appropriate. If a patient's risks were increasing, ward staff could increase the observation level, offer the patient medication prescribed on an as-required basis and remove objects that the patient could use to harm themselves. Staff also contacted doctors who could conduct a review of the patient's medication and review the arrangements for leave. When patients presented with specific risks to their physical health, staff took appropriate steps to assess and monitor these.

Staff could observe patients in all areas of the wards. The layout of wards allowed good sightlines along the corridors. Closed circuit television was installed in communal areas. There was always a member of staff on the communal areas of the wards.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff worked to ensure that all restrictions were based on individual risk assessments. For example, staff only removed mobile telephone chargers or aerosols if they presented a specific risk to the patient. Staff only searched a patient's bedroom if there was evidence to show they may have prohibited items. They said that any plans for searching a patient's bedroom would be discussed with the multidisciplinary team. Similarly, staff only carried out urinary drug screens if there was evidence showing that the patient had taken drugs.

Use of restrictive interventions

Levels of restrictive interventions were low. In the 6 months from October 2022 to March 2023, there had been 10 instances of restraint on Sandpiper ward and 7 on Starling ward. During this time, staff had used rapid tranquilisation on 7 occasions on Sandpiper ward and 6 occasions on Starling ward. The service had not used seclusion during this period.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. A healthcare assistant was leading a quality improvement programme to reduce restrictive interventions. The programme was based around a nationally recognised framework for reducing restrictive interventions known as 'Safe Wards'. The hospital had developed a plan including ten objectives focused on either working with patients, working with staff or improving the environment. Of these, 3 objectives had been completed, 5 were in progress and 2 were being planned.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff said they had a good understanding of patients' risks and triggers. This meant they could respond quickly if they felt a patient was becoming agitated. Most patients said they had not seen any incidents on the wards. One patient said they had seen an incident, but they said the staff handled the situation well.

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

Good 🟢

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. At our last inspection in August 2022, we found that staff did not always monitor the effects of rapid tranquilisation on patients' health in accordance with national guidance. At this inspection, we reviewed 3 records of physical health observations following rapid tranquilisation. Each record showed that staff recorded the patient's respirations, oxygen saturation, blood pressure pulse and temperature on at least five occasions after the medicine was administered, at 15 or 30-minute intervals. Doctors recorded their decision to end the period of enhanced observations once they were assured that there were no further concerns about the patient's physical health.

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 said they had received safeguarding training and felt confident in raising any concerns they had about abuse, or potential abuse, of patients. The service displayed information about the procedures for identifying and reporting safeguarding concerns in nurses' offices.

Staff kept up-to-date with their safeguarding training. On Sandpiper ward, 86% of staff had completed all mandatory training courses on safeguarding. On Starling ward, 100% of staff had completed mandatory training on safeguarding adults and combined training on safeguarding adults, children and young people. Ninety-four percent had completed training on safeguarding children.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff gave examples of where they had raised safeguarding concerns. For example, staff had raised a safeguarding concern after a patient had disclosed information about an incident that had placed their children at risk. Other referrals were made regarding a patient who made allegations about abuse from their partner and an incident involving the assault of a patient by another patient. The hospital reported safeguarding referrals to the local authority and kept records of the progress of all the referrals that had been made. The safeguarding lead attended quarterly safeguarding network meetings with the local authority and other health and care providers. The hospital notified the Care Quality Commission of any abuse, or allegation of abuse, in relation to a patient.

Staff followed clear procedures to keep children visiting the ward safe. Visits from children did not take place on the wards. Staff assigned rooms away from the wards for visits to take place.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital assigned two senior staff on each ward to the role of safeguarding lead, and appointed the head of occupational therapy as the overall safeguarding lead for the hospital.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive and all staff could access them easily. Patients' records were clearly written. They were informative and included details of patients' physical and mental health.

Records were stored securely. All records were stored on the electronic patient record. These records could only be accessed by staff entering a unique username and password.

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

Good ●

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed and signed medicine administration records for all patients. When dispensing medication, staff checked the chart, checked they were dispensing to the correct patient, checked they were giving the right medicine and checked the expiry date. All medicine administration records included a list of the patient's allergies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients' medicines were reviewed in their ward rounds. Doctors explained to patients the reasons for them prescribing their medicines. Staff provided written information when patients requested this. A pharmacist attended the hospital once a month to review medicines charts and provide advice on prescribing.

Staff completed medicines records accurately and kept them up-to-date. Medicines administration records were reviewed by a pharmacist. Any errors identified were reported on the electronic incident record.

Staff stored and managed all medicines and prescribing documents safely. Staff kept all medicines in a locked cabinet. All opened bottles of medicine were labelled with the date on which they were opened. There were up-to-date lists of stock medicines and a record of medicine disposals. Paper prescription pads were kept in a locked drawer in the clinic room. Staff recorded the temperature of the clinic room and the fridge used to store medication each day. All temperatures were within the correct range.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff completed a reconciliation of patients' medicines when they were admitted. When patients were discharged, staff sent a letter to the patient's GP giving details of the medicines that had been issued.

Staff learned from safety alerts and incidents to improve practice. All medicines errors were recorded on the electronic incident record. Details of safety alerts were stored in the clinic room audit folder. These were highlighted to all trained staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. There was no evidence of excessive use of benzodiazapines, hypnotic medication or medicines prescribed on an 'as required' basis.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. For example, one patient was receiving an amount of anti-psychotic medication that was above the recommended doses in the British National Formulary (BNF). Doctors followed an agreed protocol for high dose medication. This involved additional monitoring of physical health, additional blood tests and an electro-cardiogram every three months. The use of high doses of antipsychotic medication was also monitored by the pharmacist. Staff completed bowel movement charts for patients who took medication that presented a risk of constipation. Staff carried out frequent blood tests for patients taking medication that presented a risk of blood disorders. Staff checked patients' blood sugar levels before dispensing insulin.

Track record on safety

The service had a good track record on safety.

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

Good ●

The hospital collated data on safety incidents for the whole hospital. This data showed that staff had recorded 343 incidents between October 2022 and March 2023. The months with the highest number of incidents coincided with high levels of self-harm on the wards. For example, there were between 71 and 77 incidents in October, November and March. During these months, there were between 12 and 20 incidents involving self-harm. In December, January and February, there were between 32 and 47 incidents, with 1 incident involving of self-harm each month. This indicated that the number of incidents varied in relation to specific patients being at the hospital. Self-harm incidents amounted to 16% of the total. Twelve percent of incidents related to staffing and 11% related to inappropriate behaviour[APN2] by a patient.

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. Staff recorded incidents on an electronic incident record system. Between October 2022 and March 2023, staff had recorded 343 incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. In addition to reporting incidents, staff raised concerns and near misses at daily handover meetings and safety huddles.

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. Staff routinely provided a debriefing for patients involved in incidents. Details of these discussions were included in incident reports. The hospital apologised to patients for errors and mistakes.

Managers debriefed and supported staff after any serious incident. In addition, the hospital held monthly emergency scenario simulation exercises and held debriefing sessions to look at what could be learned from the exercise. Simulation scenarios had included a cardiac arrest, a patient missing in the grounds, a loss of power and a suspected poisoning.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers followed a 3-stage process for investigating incidents. An initial report was produced within 24-hours of the incident, giving details of what had happened and feedback from any debriefing with staff. A 72-hour report provided more details of lessons learned from the incident. A more thorough investigation was completed for serious incidents. This included analysis of the incident, details of policy adherence, identification of any root-causes, details of areas of good practice and details of any areas for improvement. Feedback from the patient involved in the incident was included in all these stages.

Staff received feedback from investigations of incidents, both internal and external to the service. The hospital produced a monthly newsletter for staff with information about quality and learning from incidents. A recent newsletter had included information to staff about the importance of supervising patients when opening deliveries to check for any risky or prohibited items. The importance of this had been identified following an incident at another hospital.

Staff met to discuss the feedback and look at improvements to patient care. Staff discussed feedback from incidents and emergency scenario simulations at clinical governance meetings and staff meetings.

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

Good ●

There was evidence that changes had been made as a result of feedback. For example, in November 2022, a patient absconded into the grounds and surrounding countryside. The hospital quickly arranged a search and a member of staff found the patient. However, when the member of staff called for help using their radio, there was confusion about where they were calling from. This led to a delay in additional help reaching the patient. In response, the hospital managers provided all wards with a map of the grounds, divided into clear grid references. This meant that staff could be easily located by providing a grid reference of where they were. The wards were also provided with a 'grab bag' for incidents of patients absconding in the grounds. The bags contained a torch, foil blanket and ligature cutters.

[APN1]In the North London Priory CAMHS reports I reviewed recently, Lizzie identified that there was a lack of information shared with patients about this CCTV being in place. Were these patients aware of the CCTV/been given info about it at all/posters? Just asking for consistency. I suggested a Should to Lizzie.

[APN2]Patient? Just checking not staff behaving inappropriately

Is the service effective?

Good ●

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

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients received a comprehensive review of their mental health on admission. This included an assessment of their mental capacity. The wards did not routinely provide psychology assessments for all patients, but psychologists were involved in assessment and formulation of patients who presented specific indications that they required the involvement of psychology.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Patients received a comprehensive assessment of physical health on admission. Staff recorded patients' pulse, temperature, blood pressure, respiration and oxygen saturation on admission and each day thereafter. Staff routinely carried out blood tests and electrocardiograms when patients were admitted. Doctors referred patients for magnetic resonance imaging (MRI) scans when there were indications that a patient may have an organic illness. When patients presented a higher level of risk, staff increased the frequency of these observations and carried out specific assessments and monitoring when appropriate. For example, staff completed a falls risk assessment for a patient who had low blood pressure and appeared unsteady on their feet. When assessments indicated a heightened risk of falls, they provided equipment for the patient such as bed rails, toilet seater risers and shower chairs.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff completed initial care plans that focused on keeping patients safe within the first 12 hours of admission. These care plans were reviewed after the first week when patients were more settled and able to engage more in the care planning process. Care plans included a list of interventions and treatment goals.

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

Good ●

Staff regularly reviewed and updated care plans when patients' needs changed. Plans were reviewed every 2 weeks.

Care plans were personalised, holistic and recovery-orientated. There was evidence of the patient's views in each care plan and details of the things that are important to them. For example, one care plan included details of the patient's hobbies and a list of interventions that work particularly well for them. Care plans included details of patients' risks and the steps being taken to address these.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Patients were admitted to the hospital for treatment of an acute episode of mental illness such as depression, schizophrenia, psychosis, or bi-polar disorder. A small number of patients were admitted with emotionally unstable personality disorders or anxiety disorders. Treatment involved taking medicines, engaging in therapeutic activities and attending therapy groups. The service did not provide individual psychological therapies to patients, but it did provide a programme of trans-diagnostic therapeutic groups. These groups included an emotional coping skills group, a cognitive behavioural therapy group, a compassion focused therapy group, a group for people hearing voices and a mindfulness group. The hospital also provided drama therapy. The occupational therapy team facilitated groups and activities such as a walking group, knitting and baking. Activities were facilitated six days a week, from Monday to Saturday. Approximately one-third of patients on Sandpiper ward and two patients on Starling ward were admitted after periods of self-neglect. Staff supported these patients through providing a good diet, providing a caring environment and encouraging them to attend to their personal care.

Staff delivered care in line with best practice and national guidance. For example, guidance by the National Institute for Health and Care Excellence (NICE) states that patients experiencing an acute episode of schizophrenia or psychosis should be offered oral antipsychotic medicine in conjunction with psychosocial interventions. The provision of treatment at the hospital was consistent with this. All patients with psychosis or schizophrenia were receiving antipsychotic medicine and therapeutic groups based on cognitive behavioural therapy were offered to all patients. Two patients were awaiting authorisation to begin a course of electro-convulsive therapy (ECT). In both cases, the use of ECT was only considered after an adequate trial of other treatments had been ineffective. Both patients had also made improvements following previous use of ECT. This approach was consistent with NICE guidance.

Staff identified patients' physical health needs and recorded them in their care plans. For example, a comprehensive care plan had been written in relation to a patient's diabetes, ulcerations and poor fluid intake.

Staff made sure patients had access to physical health care, including specialists as required. For example, staff supported a patient with low blood pressure to attend the general hospital for an assessment on two occasions. The assessment identified a serious medical condition.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff had completed a food and fluid chart to record the nutritional intake for a patient who had experienced poor diet and weight loss prior to admission.

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

Good 🟢

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the psychological therapies team used a clinical inventory to provide information on personality traits and psychopathy.

Staff took part in clinical audits, benchmarking and quality improvement initiatives and used results from audits to make improvements. The hospital had a structured programme of audits that were scheduled across the year. Managers completed regular audits of clinic rooms, the ward environment, ligatures, patients' physical health, care plans and observations following rapid tranquilisation. Occupational therapists completed patient engagement audits of all their activities. This meant they knew which activities were most popular and this informed their planning of future activities.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. Each ward employed nurses, doctors and healthcare assistants. The psychological therapies teams worked across all the wards. The team included a full-time counselling therapist. A behavioural therapist, psychotherapist, assistant psychologist and drama therapist all worked on a part-time basis. The hospital employed 1.6 whole time equivalent occupational therapists across all the wards.

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. Staff were required to complete competency checklists in key areas of their work. This included competency checks of controlled drug administration, observations, awareness of restricted items, searches and responding to outbreaks of Covid-19.

Managers gave each new member of staff a full induction to the service before they started work. During their induction, staff completed mandatory training. Staff spent time working alongside experienced colleagues to familiarise themselves with the ward and patients.

Managers supported staff through regular, constructive appraisals of their work. All staff had recently completed an annual appraisal.

Managers supported staff through regular, constructive clinical supervision of their work. Staff received supervision each month. Supervision sessions involved discussions about good pieces of work, any difficulties at work, incidents, safeguarding matters, wellbeing, training, staff morale and work with specific patients. Staff within the psychological therapies team received clinical supervision each month from a head of psychology within the local NHS trust. Nurses participated in regular group supervision sessions.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Each ward held a team meeting approximately once a month. These meetings followed a standard agenda, including ward updates, progress on the ward improvement plan, safeguarding, incidents and audits. The minutes of each meeting were circulated to all staff.

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

Good ●

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, staff from the therapies team had provided nurses and healthcare assistants with training on working with patients with emotionally unstable personality disorders. This included training in dialectical behavioural therapy and cognitive behavioural therapy. Some staff were undertaking specific training on phlebotomy, nutrition and psychology. One member of staff was completing an advanced nurse practitioner course.

Managers made sure staff received any specialist training for their role. In addition to the mandatory training, staff had completed courses on leadership and eating disorders.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers assessed and managed staff performance through individual, monthly supervision sessions.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The multidisciplinary team on each ward held meetings each week to review each patient's care and treatment.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Nurses and healthcare assistants held handover meetings at the start of each shift. The multidisciplinary team on each ward held a daily meeting, known as a safety huddle. The senior managers held a daily meeting, known as a flash meeting.

Ward teams had effective working relationships with other teams in the organisation. Staff from the hospital collaborated with colleagues within the organisation on specific pieces of work. For example, doctors received support and supervision from other doctors within the hospital group. Regional leads for safeguarding and the Mental Health Act also gave regular support to hospital staff.

Ward teams had effective working relationships with external teams and organisations. The wards worked closely with the local NHS trusts that had block bookings of beds. This meant that staff were familiar with the bed managers, crisis teams and community mental health teams within the local areas. For patients from other areas, staff invited care co-ordinators from their local trusts to attend care programme approach meetings to plan each patient's discharge. Staff also worked closely with the general hospital, GPs, social workers, the police and the local authority safeguarding teams.

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. Staff completed a Mental Health Act training module once a year. Compliance rates for this training were 79% on Sandpiper ward and 100% for Starling ward. Matters relating to the Mental Health Act and the Code of Practice were discussed at daily staff meetings.

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

Good ●

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. A registered nurse on each ward was assigned as the Mental Health Act lead and could support other staff on the ward with Mental Health Act matters. Responsible clinicians, the clinical director and the Mental Health Act administrator also had experience of working with the Act and could support staff.

Staff knew who their Mental Health Act administrators were and when to ask them for support. A Mental Health Act administrator was based on site. The Mental Health Act administrator had prepared information for each ward to help staff implement the Act correctly. This included providing a checklist for staff to complete when they accepted statutory documents relating to a patient's detention. Responsible clinicians said they were supported by Mental Health Act administrators.

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. All staff could access the hospitals Mental Health Act policies on the staff intranet. A copy of the Code of Practice was kept in the Mental Health Act administrator's office.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Each ward displayed information on how patients could contact the advocacy services. This information was also included in welcome packs for new patients.

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. Records of the conversations were included in the patients' notes. Staff noted on the record whether the patient understood the information. If the patient did not understand the information in the first instance, staff would explain it to them again.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Each patient's leave status was recorded in their notes. Staff discussed any plans for leave at handover meetings. Staff completed a 5-point risk assessment whenever patients went on leave. This included a brief assessment of the patient's mental state.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. However, there were delays in second opinion doctors responding to requests for assessments. One patient on Starling Ward was being treated under Mental Health Act provisions for urgent treatment whilst they were waiting for their treatment to be authorised by a SOAD.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Statutory documents were kept in a locked filing cabinets in the Mental Health Act administrator's office. Certificates of authority to administer medications to patients under the Mental Health Act were kept on the patient's medicines administration record.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Staff displayed notices at the exit to the wards informing informal patients of their right to leave.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Arrangements for discharge were agreed in care programme approach meetings for each patient. These meetings were held prior to discharge. Doctors were making an application for a community treatment order for a patient who they had assessed as requiring additional support after their discharge.

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

Good 🟢

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator used systems to monitor the application or the Act. This included monthly audits to check that detention expiry dates were correct on patients' records, checking that staff had explained patients' rights to them and checks that patients' treatment was being delivered under the correct authority. The results of these audits were reported to the monthly clinical governance meeting.

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff completed a Mental Capacity Act online training module once a year. Compliance rates for this training were 84% on Sandpiper ward and 100% for Starling ward.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. All staff could access the hospital's Mental Capacity Act policies on the staff intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The clinical director, consultant psychiatrists and the Mental Health Act administrator all provided advice to staff on the Mental Capacity Act. Staff had also sought advice from the local authority about a recent matter relating to deprivation of liberty.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. For example, staff spent time talking with a patient about their options for discharge and risks associated with their existing accommodation before they considered a referral to the Court of Protection.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. All patients received a comprehensive assessment of their mental capacity on admission. Staff used evidence based cognitive assessments and clinical examinations to support their assessments of mental capacity.

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. Doctors had assessed a patient as lacking mental capacity to make decisions about their housing. The hospital was considering an application to the Court of Protection for this patient.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. One patient was subject to deprivation of liberty safeguards (DOLS). The service had initially referred the patient for assessment under the Mental Health Act. The approved mental health professional concluded that a DOLS application would be more appropriate. The hospital had followed the appropriate procedure for referring this matter to the local authority.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. The Mental Health Act administrator submitted a Mental Capacity Act report to monthly clinical governance meetings. This included the results of monthly audits of assessments of patients' mental capacity.

Is the service caring?

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

Good ●

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 discreet, respectful, and responsive when caring for patients. Throughout the inspection, we saw staff engaging with patients in a kind, caring and thoughtful manner. When patients asked for any assistance, staff responded promptly. Overall, there was a calm and therapeutic atmosphere on the wards.

Staff gave patients help, emotional support and advice when they needed it. For example, staff offered gentle encouragement to a patient who was anxious and reluctant to leave their room. Staff offered to go for walks in the grounds with this patient and support them to engage in group work. Overall, staff had a very good understanding of their patients. This included a good understanding of patients' mental and physical health conditions, along with understanding their family relationships, personal histories, interests and worries.

Staff supported patients to understand and manage their own care treatment or condition. Nurses spent time with each patient to talk to them about their care and treatment. More formal meetings were held with the multidisciplinary team each week. At these meetings, consultant psychiatrists were able to answer questions from patients and their families about their condition and treatment.

Patients said staff treated them well and behaved kindly. Patients said that staff were kind and very supportive. They said staff treated them well and it was easy to talk to them. They felt reassured that staff spent time with patients, getting to know them. Patients said staff were professional, the understood the triggers that caused patients to become agitated and always noticed any changes in patients' moods.

Staff understood and respected the individual needs of each patient. Managers commented that healthcare assistants had a very good understanding of patients' needs. They said that healthcare assistants were aware of when there were any concerns or changes in behaviour, and they escalated these concerns appropriately.

Staff followed policy to keep patient information confidential. Staff did not discuss patients in communal areas.

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. When patients were admitted to the ward, healthcare assistants showed them around the ward and introduced them to staff and patients. Staff provided new patients with a welcome pack. These packs included information about the ward routines, restricted items, arrangements for visits and ward security.

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

Good ●

Staff involved patients and gave them access to their care planning and risk assessments. Patient said they felt involved in their care. They said they felt listened to and staff responded to their requests about leave and medications. Most patients said they had a copy of their care plan. They said they had been involved in writing and updating the plan. Each patient met with their multidisciplinary team, including their consultant psychiatrist every week. Care programme approach meetings, that included family members and care co-ordinators from patients' local areas were held at least once during each admission in order to plan the patient's discharge.

Staff involved patients in decisions about the service, when appropriate. Each ward held community meetings for patients every week. These meetings were facilitated by occupational therapists. The wards displayed the minutes of these meetings on notice boards. Managers arranged for at least one patient to attend clinical governance meetings to give their views on the service. Staff also asked patients to complete a questionnaire when they were discharged. The responses to these questionnaires were reviewed in clinical governance meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this. The hospital had recently conducted a survey of patients views on the service. The survey found that patients felt safe, the food was good and staff were supportive. However, patients raised concerns that wi-fi coverage was poor and one patient raised concerns about the times they were allowed to leave the ward to smoke. Staff acknowledged that the poor wi-fi made it difficult for patients to access email and social media, leaving them feeling isolated from friends and families.

Staff made sure patients could access advocacy services. An advocacy service visited the wards at least once every week. Information about the advocacy service was displayed on notice boards.

Involvement of families and carers
Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The consultant psychiatrist spoke regularly with patients' families. Family members were invited to ward rounds and care programme approach meetings.

Staff helped families to give feedback on the service. A carers support group was held once a month. Carers could attend this meeting remotely. At this meeting carers could give feedback on the service.

Is the service responsive?

Good ●

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

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

Bed management
Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Staff set a provisional discharge date during the early stages of admission to give an indication of the likely length of stay. This date could be adjusted during the admission according to the patient's progress.

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

Good 🟢

The service had a mix of patients from the local area and patients from other parts of England. On Sandpiper ward, 8 beds were block booked by the local NHS trust. On Starling ward, all beds were block booked by another NHS trust. Other patients came from other parts of England, including 3 patients who had been placed over 200 miles from their local area. Staff highlighted many challenges presented by patients being so far from their homes. For example, it was difficult for families to visit, patients could not go on short periods of leave to their home or areas they were familiar with and staff at the hospital were not familiar with the arrangements for community support in the patient's local area. One patient who was 200 miles from their local area had a serious physical health condition. Doctors at the general hospital had recommended they receive mental health treatment near their home, where the local hospital was familiar with the patient's history. However, NHS hospitals often had difficulty repatriating their patients due to bed shortages.

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

When patients went on leave there was always a bed available when they returned. Staff planned discharges with the patient's community mental health team. Most patients had a period of trial leave before their discharge. The patient could return to the hospital at any time during their leave.

Staff did not move or discharge patients at night or very early in the morning. All discharges were planned in advance.

A psychiatric intensive care unit (PICU) usually had a bed available if a patient needed more intensive care. Shortly before the inspection, a patient from the local area had been transferred to a PICU within two days of the referral being made. Whilst the patient was waiting for the transfer, they were nursed on two-to-one observations. However, staff said it could be more difficult to transfer patients who had been placed outside their local area.

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. Most patients were discharged to their homes as soon as they were well enough to leave. For a small number of patients, difficulties in coping at home had led to their admission to hospital which, in some cases, led to staff recommending that the patient be discharged to an alternative accommodation. This could cause delays to discharge which staff sought to address by working closely with care co-ordinators.

Patients did not have to stay in hospital when they were well enough to leave. Staff sought to give patients leave from the hospital whenever this was possible. Staff worked to ensure that patients were discharged as soon as they were well enough and engaged the crisis team in the patient's local area to manage any risks of relapse.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The discharge for each patient was planned by the multidisciplinary team and staff from community mental health teams in the patient's local area. Most patients had a period of trial leave at home before they were fully discharged. Periods of trial leave were usually supported by the crisis team in the patient's local area. When appropriate, staff referred patients for assessments under the Care Act to ensure they received services in the community after they were discharged. Staff on Starling Ward had assessed two patients as requiring further treatment in mental health rehabilitation services and were arranging appropriate placements.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

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

Good ●

Each patient had their own bedroom, which they could personalise. All bedrooms had en-suite facilities. Bedrooms had a notice board that patients could use to display cards and photographs. Patients could store personal items in a wardrobe and bedside cabinet.

Patients had a secure place to store personal possessions. Staff provided facilities for patients to store belongings safely in the ward office.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had a lounge, activity room and small rooms for individual discussions.

The service had quiet areas and a room where patients could meet with visitors in private. A family room was situated just off the ward, where patients could meet visitors. Patients could also meet visitors in a large conservatory within the hospital, or in the hospital grounds, if they had leave.

Patients could make phone calls in private. Most patients had access to their own mobile phone. Staff would only insist on withholding a mobile phone if it presented a specific risk of harmful behaviour to the patient. If patients did not have a mobile phone, they were able to use a cordless phone based in the nurses' office.

The service had an outside space that patients could access easily. Patients had unrestricted access to a tidy and well-maintained courtyard. When possible, patients had leave to the extensive, well-maintained grounds of the hospital.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients had access to a kitchen area that was well-stocked with tea, coffee, fruit, biscuits and cereals.

The service offered a variety of good quality food. Patients could choose their meals from a menu of balanced, healthy, hot and cold food.

Patients' engagement with the wider community
Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to community activities and supported patients to engage in these. For example, occupational therapy staff frequently facilitated trips for patients to go shopping, to go to the beach, to go on forest walks and to go out for coffee.

Staff helped patients to stay in contact with families and carers. At daily multidisciplinary team meetings, staff discussed the contact they and the patients had with family members. They made arrangements to ensure that patients could have phone calls and visits whenever possible. Staff recognised that some families had to travel long distances and, therefore, were flexible about visiting times.

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.

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

Good ●

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff arranged activities and events to coincide with national initiatives to celebrate minority groups such as black history month and gay, lesbian and transgender pride. Sandpiper ward had a bedroom that was adapted for patients who experience difficulties with mobility. However, the service was unable to admit patients with severe mobility or other physical impairments.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. On Sandpiper ward, staff displayed information on notice boards. This included information about physical health, treatment, local services, patients' rights, advocacy services, helplines and how to complain. On Starling ward, all this information was provided for patients in a welcome pack.

The service had information leaflets available in languages spoken by the patients and local community. The service could arrange for leaflets to be translated when this was required.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The service provided a good selection of food. Food could be prepared to meet the individual dietary needs of patients.

Patients had access to spiritual, religious and cultural support. For example, staff could arrange for a chaplain to visit the hospital if any patients requested this. Patients could use a multi-faith room for prayer and religious services. Staff had supported a patient who was observing Ramadan. They had also supported a patient to go to church.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. All the patients said they knew how to make a complaint. They said that, in the first instance, they would talk to the nurse in charge or the ward manager.

The service clearly displayed information about how to raise a concern in patient areas. Staff displayed information about how to make a complaint on notice boards on the wards. This information was also included in welcome packs for new patients.

Staff understood the policy on complaints and knew how to handle them. Between May and December 2022, the service had received 6 complaints. One complaint related to Starling ward and 5 related to Sandpiper ward. Of these, 1 complaint had been upheld, 1 was not upheld and 2 had been withdrawn. Complaints were investigated and a response sent to the complainant within one month of the complaint being made.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service sent an acknowledgement of the complaint within four days of the complaint being submitted. In some cases, the acknowledgement was sent on the same day.

Managers investigated complaints. There was scope to identify themes and discuss learning from complaints at clinical governance and team meetings. However, there had been very few complaints since the last inspection and there were no specific examples of this.

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

Good 🟢

The service used compliments to learn, celebrate success and improve the quality of care. The quality administrator received and collated all the compliments received about the hospital. These were sent to the hospital director, ward managers and shared with staff through the hospital newsletter.

Is the service well-led?

Good 🟢

Our rating of well-led improved. 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.

Ward managers were experienced registered nurses. Staff felt well supported by leaders at the hospital. They said the hospital director visited the wards each day, making them highly visible to staff and patients. Staff said there had been significant changes at the hospital and, at times, this had been difficult. However, they said that senior leaders led by example and that the hospital had made significant progress over the previous six months.

Most patients said the wards were calm, settled and well run, primarily due to staff being kind and thoughtful.

Vision and strategy

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

Staff were not aware of any specific vision or strategy, but they spoke positively about progress at the hospital and the improvements being made. They said they strived for excellence and actively looked for areas where they could make improvements. Staff had a shared understanding of the improvements and developments being sought at the hospital. Staff were seeking to make the services more person centred, safe and to improve care planning.

Culture

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

Staff spoke very positively about their work. They said they liked working at the hospital. Some staff said they particularly valued the autonomy that senior managers gave them to implement new ideas and initiatives to improve patient care. Some staff said that morale had been low towards the end of 2022, but this had improved in recent months. Staff said they enjoyed working in their teams and valued the support they received from colleagues.

Both clinical and administrative staff said there were opportunities for development. Staff from Black and other ethnic minority groups said they were treated fairly and had not experienced discrimination at the hospital.

Staff said they would have no fears at all about raising concerns with either their manager or the hospital director.

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

Good ●

The hospital engaged staff in decision making through a monthly staff forum. Each ward sent a representative to the forum where they could express any concerns on behalf of colleagues. The hospital produced a monthly staff newsletter. This included a message from the hospital director, information about projects and initiatives, positive feedback from patients and a short briefing about a particular area of work, such as safeguarding. Each month, staff could nominate colleagues for a 'Hospital Hero' award. Staff were involved in revising policies.

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.

Senior staff at the hospital attended monthly clinical governance meetings. These meetings followed a standard agenda covering patients' experiences, quality and safety, clinical effectiveness, safeguarding, workforce development, the site improvement plan and lessons learned from incidents. In addition, there were three clinical governance sub-committees that covered safeguarding, the hospital environment and patients' safety. At each meeting, 1 or 2 patients were encouraged to attend to give feedback on patient's experiences. Minutes of clinical governance meetings were circulated to senior staff at the hospital and key information was cascaded to all staff through team meetings.

Management of risk, issues and performance

The hospital maintained a risk register, setting out the operational risks to the service. The highest risks related to staffing, ligature points and risk presented to patients with unescorted ground leave. Senior managers conducted formal quality checks of each ward twice a month. This included discussions with at least 2 members of staff and 2 patients. Senior managers also conducted out-of-hours visits twice every month to monitor security arrangements at night and meet with staff working night shifts. Information from the visits was recorded and used as part of the quality assurance and governance processes.

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

Staff teams had a good understanding of patients' risks, needs and social circumstances and recorded this on the patients' electronic records. On Sandpiper ward, staff also had access to patients' records held by the NHS trust that commissioned beds there. This enabled staff to access information about patients' history of using mental health services.

Information management

Staff collected and analysed data about outcomes.

Managers reviewed data on performance and outcomes at regular clinical governance meetings. This included data about audits, supervision, incidents and mandatory training.

Engagement

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

The hospital had become more integrated with the local health and social care system through its relationships with local NHS trusts. Two NHS trusts had a block booking of beds on Starling and Sandpiper wards. This meant that the hospital was involved in bed management meetings with the trust and worked closely with these trusts to plan patients' discharges in a timely manner.

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

Good 🟢

Learning, continuous improvement and innovation

The hospital took a pro-active approach to learning, development and improvement. Since the last inspection, the hospital had introduced monthly emergency scenario simulations to ensure that staff became accustomed to responding to unexpected events and knew what to do in emergency situations. Changes had also been made to the arrangements for deliveries to the hospital to ensure that staff were aware of deliveries made to patients. The hospital had a site improvement plan to improve the ward environments.

Specialist eating disorder services

Good 🟢

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

Is the service safe?

Good 🟢

Our rating of safe improved. We rated it as good.

Safe and clean care environments
All wards were safe, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout
Staff completed thorough risk assessments of all wards areas and reduced any risks they identified. The service had a ligature risk audit to identify potential ligature risks and the mitigations in place.

Managers explained that they would only admit patients of a lower risk as the ward environment would not be suitable for higher risk patients. Each patient would be risk assessed before being admitted to the ward to ensure that the environment was suitable for them.

Patients were placed in bedrooms depending on their required levels of observation and risks. For example, 4 of the 11 bedrooms had observation panels for staff to check on patients without entering their bedrooms, 2 of the 11 bedrooms also had anti-barricade doors. Managers told us that there was a sitewide plan to reduce ligatures in patient's bedrooms to make them safer rooms. This included Skylark ward, although we were not given an estimated timeline as to when this was due to take place.

The nurse in charge completed safety checks of the environment 3 times a day and 3 times a night, however these were not always being consistently completed. For example, for 10 days in April there were gaps in the records to evidence that these had been completed. Staff were reminded in a recent team meeting to complete the records after the checks were completed.

Staff could not observe patients in all parts of the wards but blind spots were identified in the blind spot audit tool. Most staff we spoke with were aware of where the blind spots were.

Specialist eating disorder services

Good 🟢

Most staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe, although 2 out of 7 staff we spoke with were not aware of the potential ligature points within the ward. Staff had completed training on how to use ligature cutters. Although all staff knew that there were ligature cutters located in the nurse's office, 6 staff were not aware that a second pair was kept in the clinic room.

The ward complied with guidance on mixed sex accommodation, all bedrooms were ensuite. There was no dedicated female lounge, although staff were able to give examples of arrangements to meet the guidance depending on the mix of the ward. Staff explained that there were mostly female patients on the ward, at the time of our inspection there was 1 male patient on the ward. Staff explained that male patients could use a separate smaller lounge, as most female patients used the main larger lounge.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms and call buttons were installed in patients' bedrooms and communal areas.

Fire safety arrangements were in place. The ward had dedicated fire wardens and staff completed fire safety training. Personal emergency evacuation plans (PEEPS) were in place for all patients on the ward so that staff were aware of all patients who may require assistance in the event of an emergency. Staff had received training on how to use an evacuation chair for patients with low mobility.

Maintenance, cleanliness and infection control
Ward areas were mostly clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We noted that one windowsill in the patient lounge area was not cleaned, however managers explained that they were in the process of recruiting to 2 housekeeping vacancies.

Staff followed infection control guidelines, including completing annual infection control and hand hygiene training. Managers completed a monthly infection control audit, showing that staff had achieved 98% compliance in between January and March 2023.

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

Staff checked, maintained, and cleaned equipment[APN1] . Staff completed daily monitoring of the room and fridge temperatures.

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. Skylark ward could admit up to 11 patients.

During the day there were 2 registered nurses, and 2 healthcare assistants were assigned to the ward. This reduced to 1 registered nurse and 2 healthcare assistants at night. Patients told us that they felt safe on the ward and this was a standing agenda item for discussion at the weekly community meeting.

Specialist eating disorder services

The service had reducing vacancy rates. Skylark ward had 1 vacancy for a registered nurse and a deputy ward manager and 2 vacancies for healthcare assistants. The service was recruiting to vacant posts and new staff were scheduled to start in some of the vacant post shortly after the inspection. The ward had recruited 2 newly qualified nurses to work on the ward.

Managers said that these staffing allocations were sufficient to meet the needs of patients. All staff said they felt safe working on the ward but told us that there was still a reliance on agency staff to cover some shifts.

The service had high turnover rates. Between April 2022 and April 2023, 40 staff out of a total of 109 had left the service, giving an annual turnover rate of 37%. This includes 19 housekeeping and catering staff whose roles were outsourced to other companies. Managers explained that there was a restructure of non-clinical staff in 2022 and there had been a closure and reopening of one of the wards in the hospital.

Hospital managers told us that they were keen to reduce the use of agency staff and described initiatives they had introduced to encourage permanent staff to work additional shifts. Managers explained that they tried to ensure there was a permanent registered nurse or healthcare assistant on shift when an agency staff member was on shift. Managers requested bank and agency staff familiar with the ward, although this was not always possible.

Managers made sure that bank and agency staff had an induction to the service. However, staff and patients had raised concerns about the induction process for agency staff who were new to the ward and their lack of knowledge of processes of the ward, such as preparing the evening snack and completing the MARSI-MEWS observations.

Managers told us that there was an induction folder containing pertinent information to working on an eating disorders ward, such as suitable topics of conversation surrounding weight and the ward rules around access to food, drink, and exercise. However, this was not practical for agency staff to read before starting a shift. Managers have told us that they have since introduced a 'do's and don'ts checklist for new agency staff working on the ward.

The hospital had high turnover rates. Between April 2022 and April 2023, 40 staff out of a total of 90 had left the service, giving an annual turnover rate of 44%. Managers explained that there was a restructure of non-clinical staff in 2022 and there had been a closure and reopening of one of the wards in the hospital.

Levels of sickness were low. The overall sickness rate for the hospital was 3.4%. Managers gave examples of how staff were supported to return to work after a period of long-term sickness using flexible working arrangements.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers told us that they could adjust staffing levels according to the needs of the patients, such as when patients required an increase in observation levels. The service had enough staff on each shift to carry out any physical interventions safely.

Staff said that the number of staff assigned to each shift were sufficient to meet the needs of patients, however staffing was an issue when there was unexpected sickness. Managers said they were usually able to get cover promptly and staff could be used from other wards as a last resort. Managers told us that they could assign extra staff to work from 9am to 5pm to cover during staff training events.

Patients had regular one to one sessions with their named nurse, this was evidenced in the patient records.

Specialist eating disorder services

Patients rarely had their escorted leave or activities cancelled. Staff actively encouraged patients to take leave in the grounds of the hospital and engage in activities. There were sufficient staff to facilitate these activities.

The service had enough staff on each shift to carry out any physical interventions safely. Staff said that physical interventions were planned. If an emergency intervention was needed, they received assistance from staff on other wards.

Staff shared key information to keep patients safe when handing over their care to others. For example, staff worked collaboratively with other agencies when discharging patients.

Medical staff
The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. An on-call duty doctor was available for out of hours cover.

The ward had its own ward doctor and a dedicated consultant psychiatrist experienced in working in eating disorder services.

Mandatory training
Staff had completed and kept up-to-date with their mandatory training. The compliance rate for Skylark ward was 88%. The mandatory training programme was comprehensive and met the needs of patients and staff.

Courses included basic life support, infection control, health and safety, safeguarding adults and children and restrictive interventions. All courses were above 70% apart reducing restrictive interventions breakaway training which was at 66%. Staff on Skylark ward also received training on working with patients with autism, which was at 50%, managers were able to evidence that staff were booked to receive this training. Managers accessed a dashboard to monitor 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 and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk
Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed a full medical screening and risk assessment before admission to ensure that the patient's level of risk was suitable for this service. Staff said they had a good understanding of patients' risks and triggers. This meant they could respond quickly if they felt a patient was becoming unwell.

New referrals were reviewed by the consultant psychiatrist and ward dietician to ensure that patients were suitable for the service. The service did not accept patients who were at high risk of self-harm and patients that were on Nasogastric (NG)feeding. Managers told us that they planned to admit patients subject to NG feeding in future but the ward doctor was in the process of training staff in administering and managing patients requiring NG feeds.

Specialist eating disorder services

<div align="right">Good 🟢</div>

New patients were placed on one-to-one observations until they had been reviewed by a doctor. Further observation levels were agreed following this assessment based on the level of risk. Staff ensured patients presenting with increased clinical risk were supported in their bedrooms where staff could easily observe that they were safe. Patients were offered a staff member of the same gender as them, for physical examinations.

Staff discussed patient risk in daily handover meetings and reviewed risk in the weekly ward rounds with the multi-disciplinary team. Staff used a recognised risk assessment tool. We reviewed 5 patient care and treatment records and found risk was regularly assessed and reviewed for patients. This included an assessment of whether the client was at risk of re-feeding syndrome. Re-feeding syndrome is a potentially fatal condition caused by initiation of re-feeding quickly after a period of not eating. Risks were clearly identified in patient records and were updated after a change in risk or incident, including any safeguarding concerns.

Management of patient risk
Staff knew about the risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients.

Staff knew patients well and any risks to each patient and acted to prevent or reduce risks. Staff discussed patient risks in the daily handover meetings and shared key information to keep patients safe when handing over their care to others. Staff reviewed patients using a whiteboard, which detailed patient information, such as risks, eating disorder type and current therapy programme.

Staff were not able to observe patients in all areas of the ward, some convex mirrors had been installed to cover blind spots, however not all blind spots were covered by convex mirrors. Managers explained that they would only admit patients with low risk of self-harm to the ward to mitigate this.

Staff carried out varying levels of observations on patients depending on their risks, these ranged from general observations, intermittent observations, 1 to 1 observation, and arms lengths observations. Observation records showed that patients placed on intermittent observations were checked by staff four times within the hour instead of every 15 minutes within the hour.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff ensured that packages were reviewed before these were given to patients. Staff completed a 5-point risk assessment of each patient, including an assessment of their mental state, before they went on leave or participated in activities outside the hospital.

Use of restrictive interventions
Staff had a good understanding of the provider's restrictive interventions programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Levels of restrictive interventions were low. In the 6 months from October 2022 to March 2023, there were no incidents of restraint or rapid tranquilisation on the ward.

The hospital had introduced elements of the 'Safe wards' model. The model addresses how to assess and change ward culture, de-escalation and alternatives to restrictive interventions. Levels of restrictive interventions, including restraints and rapid tranquilisation were reviewed at the monthly clinical governance meeting for the hospital.

Specialist eating disorder services

Staff could use safety pods to ensure that patients were restrained in a safe manner, although 1 healthcare assistant told us that they had not received training on how to use a safety pod.

Patients were asked to sign a contract upon their admission to agree to certain restrictions on the ward during their stay, including not bringing in banned or contraband items. This also included weekly weighing, restrictions on using their smart phones and protected meal and snack times.

Staff did not impose any inappropriate blanket restrictions in treating patients with an eating disorder. Patients had access to ensuite bathrooms, staff explained that these were locked depending on the individual risks of each patient, such as if a patient was at risk of purging or water loading. Patients were supervised for 1 hour after they had their meals in the post-meal support group. Staff only searched a patient's bedroom if there was evidence to show they may have prohibited items. Patients were also individually risk assessed in whether they could use the kitchen and laundry room unsupervised.

The service had introduced an outside secure locker for patients' parcels and letters to be delivered to when the front desk was unattended. This enabled staff to supervise patients when opening their parcels to ensure that these did not contain any contraband items.

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. The compliance rate for safeguarding adults and children training was 93%.

Staff felt confident in raising any concerns they had about abuse, or potential abuse, of patients. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could discuss any safeguarding concerns with the dedicated safeguarding leads for the ward, one of which was a social worker.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff gave examples of where they had raised safeguarding concerns. For example, the ward currently had one ongoing safeguarding referral, where staff had raised a safeguarding referral after a patient had disclosed information.

Managers monitored safeguarding referrals using a safeguarding tracker and communicated with the local authority safeguarding team on the progress and outcomes of any investigations. All safeguarding incidents were reviewed at the monthly safeguarding committee. Patients were also supported to discuss any safeguarding concerns in the weekly community meetings. The hospital notified the Care Quality Commission of any abuse, or allegation of abuse, in relation to a patient.

Staff followed clear procedures to keep children visiting the ward safe. Visits from children did not take place on the ward. Staff assigned rooms away from the ward for visits to take place.

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.

Specialist eating disorder services

Good ●

Patient notes were comprehensive and all staff could access them easily. Patients' records were clearly written. They were informative and included details of patients' physical and mental health.

Records were stored securely. All records were stored on the electronic patient record, although staff told us that it was a problem accessing electronic records when the wireless internet was down.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 9 records, staff completed and signed medicines records accurately and kept them up-to-date. All medicine administration records included a list of the patient's allergies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines including the effects on their physical health. Patients' medicines were reviewed in the weekly ward rounds and the consultant psychiatrist provided advice and information to patients on the medicines prescribed. Staff carefully considered patients Body Mass Index (BMI) when establishing appropriate doses of medicine to prescribe. Staff also checked patients' blood sugar levels before dispensing insulin.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Staff had access to emergency equipment that was checked regularly including emergency medicines. Medicines were all stored in locked cabinets or medicines trolleys in the clinic room. Access to this was limited to authorised staff only. Staff took daily room and medicines fridge temperatures.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Intramuscular rapid tranquilisation (RT) was rarely used on the ward. A pharmacist attended the hospital once a month to review medicines charts and provide advice on prescribing.

Staff learned from safety alerts and incidents to improve practice. All medicines errors were recorded on the electronic incident record and discussed daily senior management meetings, patient safety meetings, clinical governance meetings and medicines management meetings. Details of medicine errors were also shared with staff in learning bulletins.

Track record on safety

The service had a good track record on safety.

The hospital had recorded 343 incidents between October 2022 and March 2023. These were broken down by incident type of self-harm, followed by inappropriate behaviour and staffing.

The ward had no serious incidents in the previous 12 months.

Specialist eating disorder services

Good 🟢

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. Staff recorded incidents on an electronic incident record system.

Staff raised concerns and reported incidents and near misses in line with provider policy. In addition to reporting incidents, staff raised concerns and near misses at daily handover meetings.

The hospital held monthly emergency scenario simulation exercises for all staff. This helped staff prepare for emergency situations and look at what could be learned from each scenario. Scenarios included a cardiac arrest, a loss of power, a suspected poisoning and a patient missing in the hospital grounds.

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. Staff routinely provided a debriefing for patients involved in incidents. Details of these discussions were included in incident reports. The hospital apologised to patients for any errors and mistakes made.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers followed a 3-stage process for investigating incidents. An initial report was produced within 24-hours of the incident, giving details of what had happened and feedback from any debriefing with staff. A 72-hour report provided more details of lessons learned from the incident. A more thorough investigation was completed for serious incidents. This included analysis of the incident, details of policy adherence, identification of any root-causes, details of areas of good practice and details of any areas for improvement. Feedback from the patient involved in the incident was included in all these stages.

Staff received feedback from investigations of incidents, both internal and external to the service. The hospital produced a monthly newsletter for staff with information about quality and learning from incidents. A recent newsletter had included information to staff about the importance of supervising patients when opening deliveries to check for any risky or prohibited items. The importance of this had been identified following an incident at another hospital.

Staff met to discuss the feedback and look at improvements to patient care. Staff discussed learning from incidents and emergency scenario simulations at clinical governance meetings and staff meetings.

There was evidence that changes had been made as a result of feedback. For example, in November 2022, a patient absconded into the grounds and surrounding countryside. The hospital quickly arranged a search and a member of staff found the patient. However, when the member of staff called for help using their radio, there was confusion about what area of the grounds they were calling from. This led to a delay in additional help reaching the patient. In response, the hospital managers provided all wards with a clearer map of the grounds, divided into clear grid references. This meant that staff could be easily located by providing a grid reference of where they were. The wards were also provided with a 'grab bag' for incidents of patients absconding in the grounds. The bags contained a torch, foil blanket and ligature cutters.

Is the service effective?

Specialist eating disorder services

Good ●

Good ●

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

Assessment of needs and planning of care

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

We reviewed 5 care records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. This included a mental state examination and an assessment of any risk the patient presented. All patients had their physical health assessed soon after admission and regularly reviewed during their stay on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed.

Comprehensive physical assessments were completed for patients on admission and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring, BMI (body mass index), dental reviews and bone density scans were completed for patients who needed them.

Staff used MARSI-MEWS regularly to monitor patient's vital signs. MARSI-MEWS is an early warning score for evaluating an inpatient with anorexia nervosa. This was developed out of MARSIPAN (Management of Really Sick Patients with Specialist eating disorder services Nervosa).

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Care plans reflected the views of patients and their relatives about their care and treatment. Staff worked with patients to regularly review and update care plans when patients' needs changed. The multidisciplinary team reviewed every patient each week and regularly updated each patient's care plan with the patient's involvement actively encouraged and supported.

Care plans included a list of interventions and treatment goals for example one patient's goal was to work towards weight restoration and recovery.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatments suitable for the patient group and consistent with national guidance on best practice. Patients had access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE).

Specialist eating disorder services

Staff assessed patients and offered a range of therapies to help them develop coping skills to manage their eating disorder. This included cognitive behavioural therapy, dialectical behavioural therapy (DBT), MANTRA (Maudsley Anorexia Nervosa Treatment for Adults), occupational therapy and enhanced cognitive behaviour therapy (CBT-E). Patients could access additional therapies, such as drama therapy, body image therapy and developing identity therapy.

Patients were offered each an individualised therapy programme dependent on their needs, including group therapies. For example, 1 patient received 1 to 1 trauma CBT sessions and attended drama therapy and body imaging groups. Staff recognised that some patients may have co-morbidities and had developed a specific pathway for patients with personality disorder with an eating disorder.

Patients told us that they could take part in a variety of activities, such as yoga on the weekends. However, these activities were not always included in the therapy timetable for the ward. This meant that some patients may not be aware of all the activities that were taking place.

Staff told us that they supported individual activities to support patients' interests, meet patients' needs and could describe what activities individual patients enjoyed. Patients raised money for an eating disorders charity by selling jewellery and textiles to other patients in the hospital on national eating disorders day.

Occupational therapists carried out a range of assessments with patients to identify their needs and functional skills, such as assessing life skills, motor and processing skills (AMPS), activities of daily living (ADL) assessments. Occupational therapists provided interventions to help patient integrate back into the community after they were discharged, such as community assessments, activities to increase self-esteem, help with applying for jobs and developing emotional coping strategies for dysregulation.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care throughout their admission, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The dietician carried out comprehensive nutritional and hydration assessments for all patients upon admission to the ward and created patient meal plans, each patient had their own meal plan folder.

Patients who were identified as being at risk of water loading had their hydration monitored effectively by staff. Water loading is where individuals consume large quantities of water so they feel less hungry or to increase their weight before being weighed. It can lead to dangerous consequences including water intoxication which can lead to seizures.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were supported to help plan, buy, prepare and cook their own meals as part of the life skills group.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Eating Disorder Examination Questionnaire (EDEQ) to measure the severity of each patient's eating disorder during their admission.

They also used the Generalised Anxiety Disorder Assessment (GAD-7) to assess the level of patient's anxiety and the Patient Health Questionnaire (PH9-Q) to assess the severity of a patient's depression.

Specialist eating disorder services

<div style="text-align: right">**Good** 🟢</div>

The Eating and Meal preparation Skills Assessment (EMPSA) was used as an outcome measure to assess patients with an eating disorder and their eating and meal preparation skills, allowing patients to rate their ability and motivation to perform tasks related to preparing and eating 'normal' meals. Although staff told us this outcome measure was currently not in use due to the occupational therapy vacancy for the service.

Staff used technology effectively to support patients. During the pandemic managers had successfully introduced online virtual family visits to maintain family contact for patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives and used results from audits to make improvements. The hospital had a structured programme of audits that were scheduled across the year. Managers completed regular audits of clinic rooms, the ward environment, ligatures, patients' physical health, care plans, safeguarding and observations following rapid tranquilisation. Occupational therapists completed patient engagement audits of all their activities. This meant they knew which activities were most popular and this informed their planning of future activities.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. This included the consultant psychiatrist, nursing staff, ward doctor, healthcare assistants, an occupational therapist, a social worker, and a dietician. The psychological therapies teams worked across all the wards within the hospital. The team included a full-time counselling therapist, a behavioural therapist, psychotherapist, assistant psychologist and drama therapist.

The hospital employed 1.6 whole time equivalent occupational therapists across all the wards, at the time of our visit the service was recruiting to an 0.8 occupational therapist vacancy.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers gave each new member of staff, including bank and agency staff, an induction to the service before they started work, although managers recognised that this could be improved.

Permanent staff completed mandatory training and were allocated an experienced buddy who supported them though the full induction process on the ward.

Staff were required to complete competency checklists in key areas of their work. This included competency checks of medicines management, safeguarding procedures, ligature risks observations, awareness of restricted items, searches and emergency escalation protocols.

Managers supported staff through regular, constructive clinical supervision of their work. Staff told us that they received monthly supervision; and 78% of staff had completed their supervision in March 2023, this had reduced from the average of 100% in February 2023. Staff within the therapies team received external clinical supervision each month. Managers supported staff through regular, constructive appraisals of their work. Staff had completed 100% of their annual appraisals on Skylark ward.

Specialist eating disorder services

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Each ward held a team meeting approximately once a month. These meetings followed a standard agenda, including ward updates, progress on the ward improvement plan, safeguarding, incidents, compliments and audits. The minutes of each meeting were circulated to all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, the dietician and senior nurse had created a bespoke mandatory eating disorder course for all new staff to complete, which included information on autism, meal preparation and body dysmorphia. This was to ensure that new staff had the knowledge and skills in working with patients with an eating disorder.

Managers made sure staff received any specialist training for their role. The ward doctor was an accredited 'train the trainer' and had planned to train staff in administering Nasogastric (NG) feeding to patients in the near future.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers assessed and managed staff performance through individual supervision sessions.

Multi-disciplinary and interagency team work

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

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. All members of the multidisciplinary team and staff worked together to understand and meet the range and complexity of patient's needs. Patients were invited in to discuss their care and treatment and where patients had given consent family members could also attend the meeting either in person or virtually. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Nurses and healthcare assistants held handover meetings at the start of each shift.

Staff had effective working relationships with the other wards in the hospital. Managers attended the monthly senior management meeting to share information from each ward and work together to resolve certain issues. For example, there had been 2 separate incidents where deliveries of restricted items had been left unattended at the reception desk, which could have patients at risk of harm. Plans taken to address this risk were discussed and actions put in place.

The ward had effective working relationships with external teams and organisations. The ward worked closely with the local community eating disorders service and child and adolescent mental health team to help support patients care and treatment. Staff also worked closely with the general acute hospital, GPs, social workers, the police and the local authority safeguarding teams.

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.

Specialist eating disorder services

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff completed a Mental Health Act training module once a year. Compliance rates for this training were 90% on Skylark ward.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. A registered nurse assigned as the Mental Health Act lead on the ward and could support other staff on the ward with Mental Health Act matters.

Staff knew who their Mental Health Act administrators were and when to ask them for support. A Mental Health Act administrator was based on site. The Mental Health Act administrator had prepared information for the ward to help staff implement the Act correctly. This included providing a checklist for staff to complete when they accepted statutory documents relating to a patient's detention.

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. All staff could access the hospitals Mental Health Act policies on the staff intranet. A copy of the Code of Practice was kept in the Mental Health Act administrator's office.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Each ward displayed information on how patients could contact the advocacy services. This information was also included in welcome packs for new patients.

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 noted on the record whether the patient understood the information. If the patient did not understand the information in the first instance, staff would explain it to them again. There was evidence that patients had their rights repeated to them on a regular basis.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Each patient's leave status was recorded in their notes and on the whiteboard in the nursing office. Staff discussed any plans for leave at handover meetings. Staff completed a 5-point risk assessment whenever patients went on leave. This included a brief assessment of the patient's mental state.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Statutory documents were kept in a locked filing cabinets in the Mental Health Act administrator's office. Certificates of authority to administer medications to patients under the Mental Health Act were kept on the patient's medicines administration record.

Informal patients knew that they could leave the ward.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Arrangements for discharge were agreed in care programme approach meetings for each patient.

Specialist eating disorder services

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator used systems to monitor the application or the Act. This included monthly audits to check that detention expiry dates were correct on patients' records, checking that staff had explained patients' rights to them and checks that patients' treatment was being delivered under the correct authority. The results of these audits were reported to the monthly clinical governance meeting.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff completed a Mental Capacity Act online training module once a year. Compliance rates for this training were 81% on Skylark ward. The social worker worked with the OT team to deliver training to all staff on Skylark ward on how to complete a mental capacity assessment.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. All staff could access the hospital's Mental Capacity Act policies on the staff intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The clinical director, consultant psychiatrist and the Mental Health Act administrator all provided advice to staff on the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Doctors reviewed patient's mental capacity in the weekly MDT meetings.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. All patients received a comprehensive assessment of their mental capacity on admission.

Staff recognised that patient's fears around food could contribute to their judgement in weighing up certain decisions which formed part of the capacity assessment. Where 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.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. There were no patients subject to the Deprivation of Liberty Safeguards on Skylark ward.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. The Mental Health Act administrator submitted a Mental Capacity Act report to monthly clinical governance meetings, which included results of monthly audits of assessments of patients' mental capacity.

Is the service caring?

Good ●

Our rating of caring went down. We rated it as good.

Specialist eating disorder services

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 discreet, respectful, and responsive when caring for patients. We observed staff treating patients with compassion and kindness. The staff and management team spoke with understanding, empathy and respectfully about the people they cared for.

Staff gave patients help, emotional support and advice when they needed it. 1 patient said that staff are 'incredibly compassionate, caring, supportive and knowledgeable.' Overall, staff had a very good understanding of their patients, including their mental and physical health conditions, along with understanding their family relationships, personal histories, interests and hobbies.

Staff supported patients to understand and manage their own care treatment or condition. Care plans detailed discussions that members of the MDT had with the patient relating to their dietary and physical and needs. Nurses met patients individually and patients were invited to attend multidisciplinary meetings with the consultant.

Staff understood and respected the individual needs of each patient. For example, staff were able to identify certain patient triggers if they were exhibiting signs of becoming distressed or change in moods.

Staff directed patients to other services and supported them to access those services if they needed help. For example, staff supported patients to access services in the community and attended appointments with them.

Staff followed policy to keep patient information confidential. Staff did not discuss patients in communal areas.

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 used the admission process to inform and orient patients to the ward. Patients received a welcome pack upon their admission, this including information about stages of inpatient treatment, visiting information, contraband items, meal planning, local resources in the community and the roles of each professional on the ward, such as occupational therapists. The welcome pack also had information and education on the nature and treatment of eating disorders and harm minimisation advice about short and long-term risks, such as re-feeding syndrome and damage to the body. This was in line with recommended national guidance.

Staff involved patients and gave them access to their care planning and risk assessments. Patients said they felt involved in their care. They said they felt listened to and staff responded to their requests about leave and medicines. All patients had a copy of their care plan, and this was discussed in the weekly community meeting.

Specialist eating disorder services

<div style="text-align: right">Good ●</div>

Staff involved patients in decisions about the service, when appropriate. Managers arranged for 1 patient to attend the monthly clinical governance meeting to give their views on the service. Staff also asked patients to complete a questionnaire when they were discharged. Feedback was collated and reviewed at the clinical governance meeting to make improvements to the service.

Patients could give feedback on the service and their treatment and staff supported them to do this. A weekly community meeting took place, that was attended by patients and the MDT. Minutes were available and detailed the feedback and requests that patients had made. Staff updated patients on any actions completed from the previous meeting and delays to any outstanding issues. Patient feedback requests were collated and displayed on a 'you said, we did' board on the ward. For example, patients requested for new tables in the dining room. Staff had listened to this request and ordered new tables.

The hospital had recently conducted a survey of patients views on the service. The survey found that patients felt safe, the food was good, and staff were supportive. However, patients raised concerns that wi-fi coverage was poor. Staff acknowledged that the poor wi-fi made it difficult for patients to access email and social media, leaving them feeling isolated from friends and families.

Staff made sure patients could access advocacy services. An advocate visited the wards at least once every week. Information about the advocacy service was displayed on notice boards.

Involvement of families and carers
Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. Family members were invited to ward rounds and care programme approach meetings. Carers were given information on the nature, course and treatment of eating disorders in a dedicated carers handbook for the ward. This was in line with the recommended national guidelines in educating families and carers about eating disorders.

Staff helped families to give feedback on the service. A carers support group was held virtually once a fortnight, where carers could feedback about the service and were able to share their experience of eating disorders with other relatives and carers. Staff had planned to reintroduce this as a face-to-face meeting either in the hospital or the local community. Carers and relatives could access support from this group after a patient had been discharged.

Staff gave carers information on how to find the carer's assessment. The social worker contacted carers and relatives of new patients admitted to the ward within 24-48 hours, with the consent of the patient. This was to obtain information about the patient, such as their triggers and family dynamics. The social worker also provided information to carers and families on how they could access a carers assessment.

Staff provided support to carers and relatives during the transitional period after a patient was discharged back home, such as helping to support carers with portion control and supporting conversations at the dining table.

Is the service responsive?

<div style="text-align: right">Good ●</div>

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

Specialist eating disorder services

Good ●

Access and discharge

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

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. 9 patients were being treated at the time of the inspection and the service had 3 out-of-area placements. The service worked closely with the provider collaborative and other commissioning teams for admissions to the service.

Managers and staff worked to make sure they did not discharge patients before they were ready, for example 1 patient was waiting for supported accommodation placement.

When patients went on leave there was always a bed available when they returned. Discharge plans were reviewed in the weekly MDT meeting.

Staff planned discharges with the patient's community eating disorders team. Most patients had a period of trial leave before their discharge. The patient could return to the hospital at any time during their leave.

Staff did not move or discharge patients at night or very early in the morning. All discharges were planned in advance.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. Most patients were discharged to their homes as soon as they were well enough to leave. For a small number of patients, it was not suitable to return to their home environment and the social worker was working with community teams and the local authority to source appropriate accommodation, including supported accommodation.

Staff carefully planned patients' discharge and worked with care coordinators to make sure this went well. The ward held a weekly multidisciplinary meeting which was also used to discuss and plan patient discharges. Patients' families and care coordinators were invited to join in person or remotely. Managers monitored the number of patients whose discharge was delayed. Delayed transfers were discussed at the senior leadership and clinical governance meetings. There were no delayed discharges on the ward at the time of our inspection.

Patients did not have to stay in hospital when they were well enough to leave. Staff sought to give patients leave from the ward whenever this was possible. Most patients had a period of trial leave at home before they were fully discharged. Staff worked to ensure that patients were discharged as soon as they were well enough and engaged the community eating disorders team in the patient's local area to manage any risks of relapse. Staff supported patients when they were referred or transferred between services, such as admission to the local hospital for physical health problems.

Facilities that promote comfort, dignity and privacy

Specialist eating disorder services

Good 🟢

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients access to drinks and snacks was in line with the treatment programme.

Each patient had their own bedroom, which they could personalise. All bedrooms had en-suite facilities. Patients had a secure place to store personal possessions and were able to personalise their room.

Staff used a range of rooms and equipment to support treatment and care. This included a large dining room, communal lounge and meeting rooms. There was no dedicated female lounge for patients, although staff said that a smaller lounge could be provided for male patients as most patients were female on the ward.

The service had quiet areas and a room just off the ward where patients could meet with visitors in private. Patients could also meet visitors in a large conservatory within the hospital, or in the hospital grounds, if they had leave.

Patients were allowed smart phones, but they agreed to sign a contract to certain restrictions whilst using them on the ward such as not posting inappropriate content on social media. If patients did not have a mobile phone, they were able to use a cordless phone based in the nurses' office.

The service had an outside space that patients could access easily. Patients had leave to the extensive, well-maintained grounds of the hospital.

Availability of drinks and snacks were considered on an individual basis and were agreed as part of patient meal plans. These were produced in collaboration with patients. Staff were able to facilitate most dietary requirements, such as gluten free diets, by using alternative substitutes to meet patients' daily nutritional intake. The catering team attended the community meeting to obtain feedback on the quality of food provided. Care plans demonstrated when patients were ready for discharge, the occupational therapists worked with patients to plan, shop and prepare meals in the rehabilitation kitchen. Patients gave us positive feedback about the food.

Patients' engagement with the wider community

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

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff made sure patients had access to community activities and supported patients to engage in these. Patients accessed the local community as part of their treatment programme, for example occupational therapy staff frequently facilitated trips for patients to go shopping and to local restaurants. This supported patients to transfer skills they had learned on the ward in relation to food related activities in the community.

The social worker supported patients who were accessing higher education by liaising with their colleges and universities. For example, 1 patient was supported to complete their final piece of coursework for their course.

Staff supported patients to maintain contact with their families and carers. Where patients consented, families and carers attended care programme approach meetings. Care records demonstrated that regular contact was maintained with family members and carers as agreed with the patient.

Meeting the needs of all people who use the service

Specialist eating disorder services

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service was located on the first floor and was unable to admit patients with severe mobility or other physical impairments due to the layout of the ward. Staff risk assessed all patients for any mobility difficulties when they were referred to the service, this was because patients were expected to use the stairs. Staff were trained in how to use the evacuation chair to assist patients with limited mobility in an event of an emergency.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The ward had a number of notice boards which displayed a range of information for patients and carers, including information about how to complain, safeguarding, eating disorders, carers support, local services and advocacy services. This information was also included in the patient welcome pack.

Managers made sure staff and patients could get help from interpreters or signers when needed. Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support.

The service was able to make adjustments to provide a variety of food to meet the dietary and cultural needs of individual patients. The dietician worked with patients to meet their dietary and cultural requirements as part of their meal plan, such as vegetarian or gluten free diets.

The ward had a dedicated dining room where patients could eat together.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas, such as ward notice boards. This information was also included in welcome pack for new patients.

Staff understood the policy on complaints and knew how to handle them. Within the last 12 months, the service had received 2 complaints. Of these, 1 complaint was partially upheld 1 was not upheld. Complaints were investigated and a response sent to the complainant within 1 month of the complaint being made.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service sent an acknowledgement of the complaint within four days of the complaint being submitted. Patients received feedback from managers after the investigation into their complaint. For example, 1 complaint concerned a patient's missing parcel and damaged medicines box, this was investigated by the manager, an apology issued and a reimbursement given.

Managers investigated complaints and identified themes and learning from complaints at clinical governance and team meetings.

Specialist eating disorder services

Good 🟢

The service used compliments to learn, celebrate success and improve the quality of care. Skylark ward had received 9 compliments in March 2023. The quality administrator collated all the compliments received about the service and these were shared with staff in the monthly clinical governance meetings and hospital newsletter.

Is the service well-led?

Good 🟢

Our rating of well-led improved. 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.

The ward manager was new in post on Skylark ward but had an extensive background in managing eating disorder services. They were supported by the Hospital Director and Director of clinical services. Staff gave us positive feedback about the new ward manager.

Staff said they felt well supported by leaders at the hospital and said that senior managers were visible and approachable on the ward.

Vision and strategy

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

Staff spoke positively about progress at the hospital and the improvements being made. The ward had an improvement plan, which staff reviewed in their monthly staff meeting. Staff had a shared understanding of the improvements and developments for the hospital.

Senior managers produced a monthly newsletter for staff which included a message from the hospital director, information about projects and initiatives, learning from incidents from other wards within the organisation, compliments, and a short briefing about a particular area of work, such as safeguarding.

Culture

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

Staff said they felt respected, supported and valued. Staff on the whole said they felt positive about working on the ward. They felt supported by the team and that the team worked well together.

Specialist eating disorder services

Staff said the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution and that any concerns they raised were acknowledged and taken seriously by senior managers.

Managers listened to feedback from the staff survey and made changes, such as introducing a monthly newsletter after staff had asked for better communication. The service had an employee of the month programme. Managers also gave a 'hug in a mug' to each staff member, which included treats.

Staff had access to support for their own physical and emotional health needs. The hospital provided an employee assistance programme where staff could access counselling, legal and financial advice.

The service did not have a dedicated staff room and 3 staff told us this would be beneficial.

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 ward or management level in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

There was a clear process for key safety and compliance information to be shared from senior leaders to ward staff and vice versa. Staff had implemented recommendations from reviews of incidents, emergency simulations, complaints, quality assurance visits and safeguarding alerts at the service level. Actions to be implemented were tracked at the monthly hospital clinical governance meetings.

Clinical governance meetings covered patients' experiences, quality and safety, clinical effectiveness, safeguarding, workforce development, the site improvement plan and lessons learned from incidents. In addition, there were clinical governance sub-committees that covered safeguarding, the hospital environment and patients' safety. At each meeting, 1 or 2 patients were encouraged to attend to give feedback on patient's experiences. Minutes of clinical governance meetings were circulated to senior staff at the hospital and key information was cascaded to all staff through team meetings.

Senior managers had plans in place to reduce identified risks to the service. They had described initiatives to reduce the use of agency staff and described, such as offering permanent staff an incentive to work additional shifts. There was also plans to reduce the ligatures on the Skylark ward inline the other adult acute wards within the hospital.

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.

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff were aware of the main risks in relation to the service they were providing. Staff concerns matched those on the service level risk register such as staffing and ligature points. The register was updated at the governance meetings and staff at all levels could escalate concerns when required. The service had plans for emergencies.

Specialist eating disorder services

Senior managers conducted formal quality checks of each ward twice a month. This included a tour of the environment and discussions with at least 2 members of staff and 2 patients. Senior managers also conducted out-of-hours visits twice every month to monitor security arrangements at night and meet with staff working night shifts. Information from the visits was recorded and used as part of the quality assurance and governance processes.

Information management

Staff collected and analysed data about outcomes and performance.

Managers reviewed data on performance and outcomes at regular clinical governance meetings. This included data about audits, supervision, incidents and mandatory training, although this could be further broken down for each ward, such as incident data.

Staff teams had a good understanding of patients' risks, needs and social circumstances and recorded this on the patients' electronic records, although staff and patients raised concerns over the poor wireless internet connection. Staff told us that they had to move to different parts of the building to access the WIFI and patients said this impacted them communicating with relatives, friends and carers. Senior managers told us that they were working on this issue and had plans in place to improve this by July 2023.

Engagement

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

The Skylark ward manager attended weekly meetings part of the local provider collaborative review. This involved close partnership working with health and social care providers within a local area. Wider issues were discussed and challenges within the system, such as the number of patients on the waiting list for an inpatient eating disorder bed. This meant that staff were familiar with the bed managers, crisis teams and community mental health teams within the local areas.

Learning, continuous improvement and innovation

The hospital took a pro-active approach to learning and improving the service. Since the last inspection, the hospital had introduced monthly emergency scenario simulations to ensure that staff became accustomed to responding to unexpected events and knew what to do in emergency situations. Changes had also been made to the arrangements for deliveries to the hospital to ensure that staff were aware of deliveries made to patients. Senior managers had also introduced a buzzer telephone system, so that visitors could contact each ward individually when the front reception desk was unmanned.

The ward participated in accreditation schemes relevant to the service and learned from them. Staff were in the process of renewing an accreditation with the Royal College of Psychiatrists', Quality Network for Eating Disorders (QED).

Staff were making improvements to the service. Staff were encouraged to develop their skills in quality improvement and contribute to the quality improvement programme. However, nursing staff noted that some improvements had been delayed by operational challenges and they did not always have time to participate in quality improvement activity.