Alternative Futures Group Limited

Millbrook

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?	Requires Improvement
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 location stayed the same. We rated it as good because:

- The ward environment was clean.
- Staff assessed and managed most risks well and stored medicines safely. Staff kept the use of restrictive practices to a minimum.
- Staff developed holistic, recovery-oriented care plans using the recovery star. Patient goals were now more clearly identified and detailed in the recovery star outcomes.
- There were good systems to ensure that staff oversaw and promoted patients' physical health.
- While there were some staff vacancies, managers had filled most of these posts and they got regular agency and bank staff to cover the shortfalls
- Staff screened patients for any psychological needs and, when patients needed psychological input, this was provided or considered.
- Staff provided recovery-focused care which helped patients to develop their independent living skills and in line with national guidance about best practice.
- Managers ensured that staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Patients were exceptionally positive about the care they received from staff and felt actively involved in care decisions. All the patients interviewed felt safe. Carers were also highly satisfied with the service.
- The service had successfully discharged several patients with complex needs with better than expected rehabilitation outcomes for these patients.
- There were good links with the local community and the newly appointed occupational therapist was working to develop these further.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. Where discharge was delayed, this was outside of the hospital's control.
- Managers had a vision for the model of mental health rehabilitation they wanted to provide. Staff felt the new managers were very approachable. Staff reported improved morale and were now confident and optimistic that they were being managed by staff who knew Millbrook well.

However:

- Staff had not acted quickly enough to resolve an issue relating to the fire safety risk audit from December 2021. For example, a drum-coiled electricity extension lead was still in use despite advice stating this should not be used due to the risk of overheating. In addition, you did not have a personal evacuation plan for a patient who refused to evacuate during a recent fire drill. These were addressed during the inspection.
- Staff had not notified us of a recent safeguarding incident. This was addressed shortly after the inspection.
- Staff were not always recording the expected or actual return time and/or outcome of agreed leave for detained patients. There had been a small number of instances where patients had been slightly late from their specific authorized section 17 leave. It was not clear that staff had discussed lateness as part of the outcome of leave to promote adherence to any conditions of leave in the future.
- There was no formal review of treatment for one relevant detained patient which should have been done when the patient's detention had been renewed as evidenced by a completed section 61 review form.

Summary of findings

- One patient who had been at the hospital some time did not have an initial or substantive care plan, risk assessment or recovery star. They did have a detailed assessment and some care documentation from the previous provider when they were in the NHS acute wards. This was addressed shortly after the inspection.
- A small number of audits had not identified issues we found on inspection or did not reflect fully the provider's own findings. They did not always clearly record what action had been taken to show shortfalls had been fully addressed or to prevent a reoccurrence. The provider had recently introduced a new system to better record evidence that actions have been completed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good 	See overall summary detail above

Summary of findings

Contents

Summary of this inspection

Background to Millbrook

Millbrook provides services for male and female patients with mental health needs who required mental health rehabilitation. It is managed by the Alternative Futures Group which is a registered charity who have several other mental health hospital and community services within the north west of England.

Millbrook is a 12-bed ward and provides rehabilitation to both patients detained under the Mental Health Act and informal patients. It provides community based inpatient mental health rehabilitation.

There is an interim manager in place who had made an application to be registered manager, accountable officer and nominated individual for this location.

The service is registered to provide the following regulated activities:

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

The local clinical commissioning group block purchases all of the beds. Any referrals from outside the local area would be funded by the patient's local clinical commissioning group.

Millbrook has been registered with CQC since December 2010. There have been six previous inspections at Millbrook, the most recent being January 2019. On that inspection, we rated Millbrook as good overall and across all five key questions we asked (whether services are safe, effective, caring, responsive and well-led).

Staff were ensuring that ratings were displayed in a prominent place as required. The provider has a duty to ensure the ratings we give are displayed appropriately so patients, visitors and the public can easily see the hospital's ratings. On this inspection, we found that the current ratings were displayed on the provider's website**.** The current ratings were also displayed near the hospital's reception area.

What people who use the service say

We spoke with six patients who used the service and three relatives. All of the patients were very complimentary about the standards of care and about staff that provided the care and treatment. They reported the hospital had excellent, caring and professional staff. They stated that there was a wide range of activities including days out, restaurant trips, shopping trips, cookery sessions and money management sessions. They reported that the occupational therapist was brilliant and had made a massive difference to the quality of care at the hospital.

Patients stated they received recovery-focused care which helped them to develop their independent living skills. They stated staff provided a holistic approach to care which focuses on mental well-being as well as physical well-being.

Where patients reported less positive feedback, it was mostly relating to the provider's recent decision to remove the facility of the hospital car which was used for appointments and days out. We spoke with managers about this who explained that the decision was made to support and encourage patients to use the very good transport links to travel as part of maximising their rehabilitation and equip them with independent living skills on discharge.

Summary of this inspection

We spoke with three relatives. Family members were extremely positive about the quality of care their loved ones received at Millbrook. Family members told us that they were very confident and highly satisfied with the service. They felt listened to and stated there was great family involvement. Family members told us they were made to feel welcome when visiting for example they were offered refreshments.

How we carried out this inspection

We undertook this inspection as part of a random selection of services rated 'good' and 'outstanding' to test the reliability of our new monitoring approach.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information. We asked the local Healthwatch and local commissioners for information they held on the service.

During the announced inspection visit, the inspection team:

- visited the hospital and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with six patients and three relatives
- spoke with the interim manager
- spoke with six other staff members: including the consultant psychiatrist, nurses, support workers and an occupational therapist
- spoke with a representative of the local integrated care group who commission beds at the service
- attended and observed one clinical meeting
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management on the unit
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Summary of this inspection

Outstanding practice

The service had successfully discharged several patients with complex needs successfully with good outcomes for these patients. This included patients who were rehabilitated and discharged into their own homes. Many of these patients were expected to go into some form of residential care when they were first admitted to Millbrook.

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with three legal requirements.

- The provider must ensure that they assess the risks to service users and doing all that is reasonably practicable that the identified risks were mitigated (Regulations 12 (1) (2) (a) and (b).
- The provider must ensure that equipment was safe and used in a safe way (Regulations 12 (1) (2) (a) and (e).
- The provider must ensure that it maintains an accurate, complete and contemporaneous record in respect of each service user and any decisions taken (Regulations 17 (1) (2) (a) (b) and (e).

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

Action the service SHOULD take to improve:

- The provider should ensure that all the audits are robustly completed to assess, monitor and improve the quality of the service. The provider should check the audits for completeness and embed the new system to better record evidence that audit actions had been completed.
- The provider should ensure that its own audits fully anticipate key dates relating to the review of treatment rules relating to the Mental Health Act to prevent a reoccurrence of the shortfall.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Requires Improvement

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

Safe and clean care environments

The ward was safe, clean, well furnished, and well maintained. Not all equipment used was fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced most risks they identified. Not all equipment used was fit for purpose. While most checks showed that action was taken, the provider had not acted quickly enough to resolve an issue relating to the external fire safety risk annual audit from December 2021. They were still using a drum-coiled electricity extension lead in the main lounge despite advice stating this should not be used due to the risk of overheating. The drum-coiled electricity extension lead was in use until we pointed it out. Managers addressed this straightaway and an ordinary extension lead was purchased and used. There were other identified actions on the annual fire audit that had been addressed or the risks mitigated while more substantial work was carried out. The service only had one floor and was all on one level and plenty of fire exits throughout the building.

Staff could observe patients in the main parts of the wards. Millbrook was a single-storey building providing community based inpatient rehabilitation care and treatment. There were twelve en-suite bedrooms and two self-contained bedsits.

The ward complied with guidance and there were no mixed sex accommodation breaches. All rooms were individual en-suite, so patients had their own shower and toilet facilities. Patients did not have to walk through an area occupied by another sex to reach a toilet or bathroom. There were separate toilets and one shared bathroom with a bath. There was a separate women only lounge.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service only admitted patients who had been assessed as low risk of self-harm. Millbrook had two bedrooms modified for patients who were at higher risk of ligature with anti-ligature bathroom fittings, piano hinges on the wardrobes and other

adaptions. This enabled staff to manage patients in an appropriate environment if their risk of self-harm increased following admission. Across the other bedrooms, risks were mitigated by patient admissions, staffing levels alongside a positive risk-taking approach as a community rehabilitation unit and staff carrying out observations, where necessary. There were also plans to make all bedrooms anti-ligature to make the environment even safer.

Staff had easy access to alarms and patients had easy access to nurse call systems. Nurse call systems were available for patients in bedrooms and communal areas.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Managers ensured that they carried out the necessary statutory health and safety checks and assessments by external contractors. These included annual environmental risk assessments such as gas and electric safety assessments, fire risk assessments and appliance testing. Apart from the continuing use of the drum-coiled electricity extension lead,

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. During the COVID-19 pandemic, Millbrook continued to admit and care for patients. Managers had put in control measures to prevent and control infection, including regular testing of staff, checking that visitors had no symptoms that may indicate COVID-19, enhanced cleaning procedures, and additional staff training.

Millbrook as part of its model of care, did not have a seclusion facility. Staff would not admit patients if seclusion was likely as part of an individual management plan. The current patients did not present with significant, ongoing management problems.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room included room for medicines storage, including proper storage for controlled drugs which met national guidelines. Staff administered and dispensed most medicines to patients over a stable-type door, except when more privacy was required. There was no room for a private area for patients to be examined within the clinic room. This would usually take place either in patients' bedrooms or in a room designated for patient's physical health. The clinic room was in good order and clean.

Staff checked, maintained, and cleaned equipment. Staff completed appropriate checks to ensure that equipment was clean and ready for use.

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. On each day shift there was one qualified nursing staff and three nursing assistants. Each Tuesday, an extra nurse was deployed during the day to assist with weekly ward rounds, care programme approach meetings and mental health tribunals which were usually arranged for that specific day. On each nightshift there was one qualified nursing staff and two nursing assistants. These staffing levels were maintained.

Long stay or rehabilitation mental health wards for working age adults

Good

The service had low staff vacancy rates with plans in place to fill vacant posts. There were three nurse vacancies, but all of these vacancies were soon to be filled following a successful recruitment drive. There were two health care assistant vacancies. There were well advanced plans to recruit to these health care assistant posts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Due to vacancies, the service had increased the use of bank and agency nurses and nursing assistants. The hospital regularly used three bank nurses who previously worked at the hospital so knew the hospital well and provided consistent nursing care.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Alternative Futures Group had an electronic staff rota system. The system ensured that bank staff deployed to work at Millbrook were up to date with mandatory training.

The service had relatively low turnover rates at 5.1% in April 2022. When staff left Millbrook, it had usually been for progression in their careers or promotion internally or externally.

Managers supported staff who needed time off for ill health.

Levels of sickness were slightly higher than average. The sickness rates for the year April 2021 to March 22 was 8.5%. This meant that sickness rates were slightly higher when compared to an England average of 6.9% sickness rate for NHS mental health and learning disability hospitals according to the most recent annual figures (for January 2022).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Staffing levels were increased in line with patient's needs, such as escorted leave, attendance at other hospitals or increased observational levels.

Patients had regular one- to-one sessions with their named nurse. These regular sessions were well recorded in patients' notes.

Patients rarely had their escorted leave or activities cancelled. Nursing staff were visible on the ward providing care and treatment to patients. Staff and patients told us leave or activities were never cancelled. The service had enough staff on each shift to carry out any physical interventions safely.

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

were appropriate handovers between the different shifts so relevant information was shared.

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. One consultant psychiatrist working for a nearby mental health NHS trust provided consultant psychiatrist input through a service level agreement contract. The psychiatrist had worked at Millbrook for several years so had provided significant continuity of medical input. The psychiatrist oversaw the mental health rehabilitation pathway for all Manchester residents and across three mental health inpatient units including at Millbrook. The psychiatrist attended weekly and ensured that each patient was reviewed at these meetings.

Managers could call locums when they needed additional medical cover. During out of hours and when the psychiatrist was on leave or away, psychiatric input came from the doctor on call from the trust. These arrangements were reported to work well.

Patients were also registered with two local GPs who provided medical input for physical health conditions, including completing comprehensive annual physical health reviews.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Most staff at Millbrook had completed training as part of their induction and ongoing refresher training with an overall uptake rate of 74%. Some of the main topics included in this training course were: -

- intensive life support
- personal safety
- safeguarding
- health and safety
- moving and handling
- recovery star
- management of violence and aggression
- positive behaviour support
- slavery and human trafficking.

The lowest uptake rates were due to a pause on face to face training during the COVID-19 pandemic such as face to face Therapeutic Management of Violence & Aggression level three training. Where training uptake rates were lower, managers had plans in place to ensure staff completed the training quickly to improve uptake rates and refresh staff knowledge.

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

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

Assessing and managing risk to patients and staff

Staff knew about any risks to each patient but were not always fully acting to prevent or reduce risks. Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint 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

Patient risk assessments did not always include a proper and full assessment to minimise the risk to and from individual patients. Staff completed risk assessments for most patients on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at seven patient's care records. These contained an up-to-date and detailed risk assessment. On one record out of seven that we looked there was no individual patient risk assessment. The patient had been at the hospital since mid-May 2022 but they did not have an initial or fuller risk

assessment or risk management plan. They did have a detailed admission assessment by Millbrook staff and risk assessments from the previous provider when the patient was in the NHS acute wards. Managers accepted the shortfall. Staff knew the patient very well and the patient was very happy with the standard of care they received. This was addressed shortly after the inspection.

Staff used a recognised risk assessment tool. Patient risk assessments were completed using a recognised risk assessment tool on admission and, with the one exception, were reviewed regularly to monitor any changes in patients' risk.

Management of patient risk

Staff knew about any risks to each patient but were not always fully acting to prevent or reduce risks.

Patient risk assessments did not always include risk management plans detailing the action staff needed to take to minimise the risk to and from individual patients. On the same record where there was no risk assessment, there was no individual written patient risk management plan. Staff knew the patient very well and the patient was very happy with the standard of care they received. This was addressed shortly after the inspection with a detailed plan. The other risk assessments were completed to a good standard and regularly reviewed.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff provided appropriate support to monitor and manage risk using positive risk-taking approaches.

Staff did not routinely search patients. Staff had guidance to follow if they needed to search patients or their bedrooms to keep them safe from harm.

Staff were not always recording the expected or actual return time and/or outcome of agreed leave for detained patients. There had been a small number of instances where patients had been slightly late from their specific authorized section 17 leave. It was not clear that staff had discussed lateness as part of the outcome of leave to promote adherence to any conditions of leave in the future and also how they would easily oversee when patients were expected to return.

The provider's fire risk assessment completed in March 2022 stated that no service user required assistance. However, on a routine fire drill in January 2022, one patient refused to evacuate, and the full zoned evacuation took 16 minutes as a result. Through our checks and managers confirmed that this patient did not have a personal evacuation plan to address this refusal incident to enable staff to be aware that the patient may refuse and the strategies to assist in any future necessary emergency evacuation. These were addressed during the inspection and an individualised personal evacuation plan was put in place.

Use of restrictive interventions

Levels of restrictive interventions were low and were being reduced. Most patients were detained under the Mental Health Act, but many had unescorted leave. Each patient had a detailed, individualised assessment plan in place to ensure that any restrictions were kept to a minimum. These assessment plans included assessing restrictions related to medication, equipment, the environment and any other restrictions in place. These were regularly reviewed for each patient.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There were no blanket restrictions in place; patients had access to fresh air, mobile phones and their possessions.

The front door was locked but all the patients had ready access to the grounds and gardens with the back door open throughout the day. There were notices by the front door informing informal patients and patients with unlimited unescorted leave of their right to leave and that they just needed to ask staff to open the door.

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. Restraint was not regularly used at Millbrook as a mental health rehabilitation ward. In the last 12 months, there had been one recorded incident of restraint on one patient; none of these were prone (face down) restraints. Staff told us that they knew patients well and were skilled at de-escalating patients when they became agitated or distressed. Where there were incidents, they were mostly incidents of verbal aggression between patients.

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

Staff followed NICE guidance when using rapid tranquilisation. There had been no recent episodes of rapid tranquilisation. If it was required, staff would consider whether the patient was suitable for rehabilitation.

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 could describe the safeguarding reporting process in the hospital. Staff described that they reported any incidents to the clinical lead nurse or interim manager. Alternative Futures had its own safeguarding policy and procedure. The policy guided staff to follow the local safeguarding procedures.

Most staff were up to date with their safeguarding training. The compliance rate was 90%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw a protection plan was in place for one patient to ensure they were safeguarded fully.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were posters displayed for patients to inform them of safeguarding, their right not to be subject to abuse and how to raise a safeguarding alert.

We had not received any safeguarding notifications relating to allegations of abuse in the 12 months prior to the inspection. Managers of the hospital were aware of their responsibilities to notify us appropriately of any safeguarding allegations. However, they had not notified us of a recent safeguarding incident between patients which they had referred to the local authority. Managers notified us shortly after the inspection.

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.

All staff could access patient notes easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Patient records were mostly held electronically with some paper records. Managers were looking to improve their arrangements for keeping detention papers as they allowed staff to access to the original patients' detention papers and associated records (such as section 17 leave forms). The original Mental Health Act paperwork for each patient was kept in legal files. These files were accessible to nursing staff so there was a danger that original detention papers may go missing inadvertently which had the potential to lead to detentions having to lapse if all the legal paperwork was not available. The provider was looking into getting a lockable safe to store original detention papers and ensure that only the copied detention papers were available to staff.

Records were stored securely. Staff kept records securely in the locked staff office. Managers kept archived patient records in storage in a separated locked cupboard. The archive was very orderly so staff would easily be able to find specific archived records easily.

Staff were aware of their responsibilities to keep patients' information confidential.

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 but did not always complete the associated legal forms when required.

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

Staff completed medicines records accurately and kept them up to date. Medicine charts were up-to-date and clearly presented to show the treatment people had received.

Staff reviewed each patient's medicines regularly but did not always complete the review paperwork in line with legal requirements when patients were detained. The Mental Health Act requires that when detained patients are given medicines for a mental disorder legal forms are to be d, usually after three months, (section 58 of the Mental Health Act) and when a patient's detention was renewed (section 61 of the Mental Health Act). Where treatment for mental disorder was given to detained patients usually after three months, the relevant legal authority for treatment (known as a T2 or T3 form) was in place. We also saw there was regular reviews of people's medicines at ward round and also regular reviews of patients' capacity to consent. However, for one relevant patient, there was no relevant formal legal form completed by the responsible clinician showing this review of medical treatment. This review was required for relevant patients who had been subject to a second opinion appointed doctor authorisation (T3) and whose detention had subsequently been renewed (as evidenced by a completed section 61 review forms). Completed section 61 form should also be sent to CQC for relevant patients but we had not received any. For example, one patient had been detained for over four years and had a second opinion appointed doctor certificate throughout this time but there was no section 61 form evident for each time the patient's detention was renewed. Managers explained that the provider had a service level agreement with the nearby mental health NHS Trust for medical cover and Mental Health Act administration and were meeting with administrators to review and fully clarify shared responsibilities.

Staff provided advice to patients and carers about their medicines. As part of rehabilitation, staff spoke with patients about medicines to help them gain insight into medicines they were taking and their importance in recovery.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff stored and managed all medicines and prescribing documents safely. Staff had processes for the management of medication, which included prescribing, ordering, storage, administration and disposal. Staff accounted for the type and number of controlled drugs properly in a controlled drug register. Controlled drugs are medicines that require extra checks and special storage because of their potential for misuse.

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

Staff had assessments and procedures for the staged process for patients self-administrating their own medication, with decreasing levels of supervision from nursing staff. Four patients were on self-medicating regimes to varying degrees. This was risk assessed based on patients' level of insight and responsibility around taking medication.

Staff learned from safety alerts and incidents to improve practice. Staff were aware of alerts such as the need for caution when prescribing sodium valproate to women.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Two out of twelve patients were on high-dose anti-psychotics, which was where anti-psychotic medicines are given above British National Formulary (BNF) recommended levels either in a single or a combined dose. Clinicians reviewed patients on high dose anti-psychotics to check that the regime was still needed. Patients received regular physical health monitoring checks to make sure they were not experiencing significant adverse effects of long term and high dose anti-psychotic use. However, neither of these two patients had current care plans addressing the use of high dose antipsychotics or current completed high-dose anti-psychotic monitoring forms (which had been developed by the provider to ensure that these checks occurred). Managers addressed this soon after the inspection.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients were offered medicines to counteract any side effects such as excessive saliva and muscle stiffness. Patients were encouraged to attend the community Clozapine clinic to have their blood taken and to monitor their health. This was run by the nearby NHS mental health trust but was seen as a very important part of patients' rehabilitation to use the community clinic facilities.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and usually 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. The service had no never events.A 'never event' is a wholly preventable serious incident that should not happen if preventative measures are in place. In mental health services, the relevant never events within hospital settings were actual or attempted suicide of a person due to the failure to install functional collapsible shower or curtain rails and falling from an unrestricted window.

There were 99 incidents reported for the 12 months up to 1 June 2022. Out of these 47 incidents were minor medicine errors which were usually relating to missing signatures of staff with most of these involving agency nursing staff failing to fully sign the administration of non-critical medicines.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff reported serious incidents clearly and in line with company policy. The hospital had a standard system of incident monitoring. Of the 99 incidents reported for the 12 months up to 1 June 2022, all were recorded as either low or no harm incidents. Staff we spoke with understood the types of incidents to report.

All independent hospitals were required to submit notifications of incidents to the CQC. The hospital had not always notified us of appropriate relevant incidents. This was because managers had not notified us of one recent safeguarding incident between patients which they had referred to the local authority. Managers notified us shortly after the inspection. In the 12-month period up to June 2022, there were two notified incidents. These related to two police incidents which involved the police being called where detained patients had failed to return from authorised leave.

Staff understood the duty of candour. Managers were aware of their responsibilities in relation to duty of candour which required staff to be open and offer an apology when an incident occurred resulting in serious harm. There had been no notifiable events which met the threshold of moderate or severe harm under duty of candour in the last 12 months.

Managers investigated incidents thoroughly. Managers had taken appropriate action to ensure any incidents were looked at fully. Managers debriefed and supported staff after incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff completed safety drills which included a scenario and staff were assessed on how they responded.

There was evidence that changes had been made as a result of feedback. We saw that improvements had been made following incidents. These included managers holding individual discussions in supervision with staff and assessments of staff competence and improvements following medicines errors.

Are Long stay or rehabilitation mental health wards for working age adults 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. In the majority 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 for most patients either on admission or soon after. Assessments were completed by one of the three providers of mental health rehabilitation services in Manchester using a common assessment framework. This helped to ensure that patients did not have to have several assessments by different providers asking similar questions. On all seven patients' files we looked at, we saw a detailed mental health and rehabilitation assessment and associated care plan. We saw evidence that this assessment tool was being used by staff to plan care with patients.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Each patient received regular and routine on-going monitoring of health conditions. Care plans were in place to support people's physical healthcare needs such as diabetes and asthma.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff developed a comprehensive care plan for most patients that met their mental and physical health needs. Staff and patients worked together to produce an overarching care plan that looked at their holistic needs. This followed the format of a recognised recovery-based assessment tool (the mental health recovery star). This tool assessed and provided guidance on recovery-based support to people with mental health needs. The mental health recovery star was a collaborative tool and allowed patients to set their own three most important goals for rehabilitation and map their own progress against these goals. We saw this was well completed for six out of seven files we looked at. However, for one patient admitted in May 2022, we saw that they did not have an initial or substantive care plan. They did have a comprehensive assessment which identified their needs fully which included an outline care plan. Managers ensure this was rectified quickly and a detailed and individualised care plan was put in place. The manager understood why this had not been completed and put measures in place to prevent a reoccurrence.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans and risk assessments were updated on an electronic records system while a paper patient file was also kept and available to all staff.

Care plans were personalised, holistic and recovery orientated. Care plans contained up to date,

recovery focused information to support the treatment pathway. Care plans provided good information for patients and staff (including new staff) to fully understand what patients' strengths and needs were and how their needs were being met.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. Patients received individualised treatment, interventions and practical support to aid their mental health rehabilitation and recovery. This included named nurse sessions on medicines, relapse prevention and insight, access to appropriate help with budgeting, and assessments and assistance with activities of daily living, such as road sense, shopping, cooking and cleaning. Patients were supported to access social, cultural and leisure activities, education and vocational resources to help aid their recovery.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g., NICE). For example, guidance on the treatment of schizophrenia. Patients received support from staff and medicines to minimise symptoms of their mental health through both medication and psychosocial interventions. Patients on Clozapine attended the local Clozapine clinic. There was a process for patients and staff to record and display patients' progress on their recovery journey known as 'butterfly moments'.

Staff identified patients' physical health needs and recorded them in their care plans. Patients were supported to regularly use the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) tool which was a is self-rating scale for measuring the side-effect of antipsychotic medications so these could be managed. This meant that staff could prescribe medication at a level that relieved patients' symptoms of mental ill health while ensuring that side effects were minimised.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff made sure patients had access to physical health care, including specialists as required. Patients were encouraged to visit and speak to the GP about any physical health concerns. The GP carried out annual comprehensive physical health checks.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff completed diabetes management training and patients with diabetes were given appropriate meals to meet their dietary needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There were a variety of methods staff used to encourage healthy lifestyles. For example, staff held group meetings for healthy eating and one patient had a pedometer and had agreed targets to increase their walking steps each day.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff commonly used a rating scale for the positive and negative, symptoms and severity of hallucinations and delusions. The occupational therapist routinely used a recognised tool to gain an understanding of a patient's functioning.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff regularly monitored and updated patients' progress using the recovery star. Managers routinely monitored the overall effectiveness of patient rehabilitation and recovery progress such as formally reviewing the progress across all patients' recovery outcomes.

Managers used results from audits to make improvements. Most audits were largely effective in identifying and addressing shortfalls. For example, we saw good physical health checks being carried out supported by a comprehensive audit. We saw improvements in medicines recording and ensuring that medicines charts were written in capital letters to avoid future mistakes.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. Patients received multi-disciplinary input from medical staff, nurses, healthcare assistants and an occupational therapist.

Patients were now screened for psychological input and were referred for cognitive behavioural therapies, other therapies and clinical psychology input as required. This meant that patients now were assessed and had access to talking therapy and other treatments to aid their recovery in line with best practice. One patient was offered family therapy, but the family declined to take part. Patients were also registered with a GP for physical health assessment and ongoing checks.

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 we spoke with had a good understanding about supporting patients' recovery and address patients' individualised needs including promoting good mental health, psychosocial approaches, supporting patients to adhere to the medicines prescribed for their mental health, improving insight, everyday living skills and support with meaningful activities and occupation.

Managers gave each new member of staff a full induction to the service before they started work. This included corporate and mandatory training and time shadowing shifts.

Managers supported staff through regular, constructive appraisals of their work. All staff had received a 'my performance' appraisal in the last year.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Most members of staff had regular supervision every two months as well as coaching and mentoring. Staff had access to clinical supervision. The supervision uptake rate for the year up to June 2022 was 76%. The occupational therapist accessed regular external supervision which the company paid for.

Managers supported medical staff through regular, constructive clinical supervision of their work. Medical staff received their ongoing medical supervision, appraisal and revalidation through their employment at the nearby NHS mental health trust.

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

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

Managers made sure staff received any specialist training for their role. Staff confirmed that they had received additional training, and this was confirmed by training records seen. This included training on a whole range of mental disorders for all staff. Some nurses were completing training on mentoring, psycho-social interventions, phlebotomy and/or podiatry training. One nurse was looking to become a non-medical prescriber.

Managers recognised poor performance, could identify the reasons and dealt with these. Where staff had identified competency or capability issues, managers took action to ensure staff were supported and/or their performance was addressed.

Multi-disciplinary and interagency teamwork

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

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary team meetings occurred every week with each patient usually being discussed at least once per month.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Patient care, treatment and risk assessments were reviewed regularly to monitor any changes in patients

The ward team had effective working relationships with other teams and professionals. Staff could access other professionals for patients via referral through the GP, for example dietitian or speech and language therapy

The ward team had effective working relationships with external teams and organisations. Patients received support from a care coordinator from the local mental health trust's community mental health teams. The records showed they

were routinely invited to multidisciplinary and care programme approach meetings. However due to pressures on the local community mental health teams, staff from these teams were not always able to attend. This was beyond the full control of the hospital. Managers at the hospital were hopeful there may be improvements with a new community rehabilitation team being developed.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff had received training in the Mental Health Act. Staff we spoke to had a good understanding of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff from a nearby mental health NHS trust provided ongoing Mental Health Act administrative support through a service level agreement. The administrator's own systems identified an incident where one patient's detention was not renewed due to an oversight. This was addressed by the time of the inspection. Staff at Millbrook had introduced a further monthly check to ensure that key dates relating to the Mental Health Act were not missed.

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. The provider had relevant policies and procedures that had been developed in line with the most recent guidance and staff knew how to access them.

Patients had access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients had access to an independent mental health advocacy service as a representative from the local advocacy visited on a referral basis, in line with recovery principles.

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. Detained patients were informed of their rights on admission and frequently through their detention.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Most patients had significant section 17 leave. Staff ensured that section 17 leave decisions were well recorded with clear conditions. However, staff were not always recording the expected or actual return time and/or outcome of agreed leave for detained patients.

Staff usually requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. When consent was discussed with patients, responsible clinicians completed an assessment of capacity and consent for treatment for mental disorder. There had been a recent incident where one patient's prescribed treatment was changed and although they were covered by urgent treatment rules there was a delay in the Second Opinion Appointed doctor authorisation. By the time of the inspection, this was resolved.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. The original Mental Health Act paperwork for each patient was kept in legal files. Managers were looking into getting a lockable safe to store original detention papers and ensure that only the copied detention papers were available to staff.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. There were three informal patients at the time of the inspection. Information was displayed to tell informal patients that they could leave the ward freely.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and most audits were completed to a good standard and discussed the findings. In addition to the systems and checks carried out by the Mental Health Act administrators working for the nearby NHS mental health trust, staff undertook monthly audits of adherence to the Mental Health Act. The themes covered within the audits included section 17 leave, consent to treatment, second opinion processes, detention renewals, and information provided to detained. The main findings within recent audits showed good adherence. Most audits were completed to a good standard. However, monthly audits of Mental Health Act paperwork did not identify the lack of an appropriate section 61 form in one case which are the forms completed to review treatment and section 17 outcome recording.

Good practice in applying the Mental Capacity Act

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

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

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Patients in the service were detained under the Mental Health Act. Staff made treatment decisions for mental disorder under the legal framework of the Mental Health Act. We saw that patients' mental capacity to consent to their care and treatment had been assessed as required.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples of good capacity assessments made in line with the principles of the Mental Capacity Act.

When staff assessed patients as not having capacity, they looked to make decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. The hospital had a best interest checklist form which covered the legal requirements when looking at best interests

Long stay or rehabilitation mental health wards for working age adults

Good

We saw where patients lacked capacity to make decisions, key members of staff met to consider whether those specific decisions were in the patients' best interests. They invited key professionals to these meetings such as staff from patients' community mental health team. Examples of decisions included whether it was in a patient's best interest to give up their tenancy for social housing and the support package on discharge and aftercare. During the inspection, we attended a best interest meeting for one recently admitted patient, but this could not go ahead fully as the patients' care coordinator did not attend to provide information and help with the decision.

Staff were aware of the Deprivation of Liberty Safeguards order processes so they could apply when necessary and monitor the progress of these applications. There were no Deprivation of Liberty Safeguards applications made in the last 12 months. There were no patients subject to the Deprivation of Liberty Safeguards at the time of our inspection. Staff were able to describe when the safeguards may be used.

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

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

We spoke with six patients who used the service and three relatives. All of the patients were very complimentary about the standards of care and about staff that provided the care and treatment. They reported the hospital had excellent, caring and professional staff.

Staff were discreet, respectful, and responsive when caring for patients. Patients reported that staff were very kind and friendly.

Staff gave patients help, emotional support and advice when they needed it. Records showed that patients had regular one-to-one meetings with their named nurse. Patients stated they received recovery-focused care which helped them to develop their independent living skills. They stated staff provided a holistic approach to care which focuses on mental well-being as well as physical well-being.

Where patients reported less positive feedback, it was mostly relating to the provider's recent decision to remove the facility of the hospital car which was used for appointments and days out. We spoke with managers about this who explained that the decision was made to support and encourage patients to use the very good transport links to travel as part of maximising their rehabilitation and equip them with independent living skills on discharge.

We spoke with three relatives. Family members were also extremely positive about the quality of care their loved ones received at Millbrook. Family members told us that they were very confident and highly satisfied with the service. Family members told us they were made to feel welcome when visiting for example they were offered refreshments.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff supported patients to understand and manage their own care treatment or condition. Patients stated that there was a wide range of activities including days out, restaurant trips, shopping trips, cookery sessions and money management sessions. They reported that the occupational therapist was brilliant who had made a massive difference to the quality of care at the hospital.

Staff directed patients to other services and supported them to access those services if they needed help. Patients received ongoing support and encouragement to help them reach their rehabilitation goals, for example, staged support to self-manage medication and support to shop for food and cook independently. Staff supported patients and ran groups to support patients with life outside Millbrook including proactive, regular help to apply for social housing on discharge.

Patients said staff treated them well and behaved kindly. We observed very positive and warm interactions between patients and staff.

Staff understood and respected the individual needs of each patient. Staff had a very good understanding of the needs of patients in their care. Staff could identify quickly if patients' mental health was relapsing.

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

Staff followed policy to keep patient information confidential. There had been no patient data breach incidents at the service.

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 completed an admission checklist when patients first came which showed that patients had been shown around and given information about the hospital and its rules.

Staff involved patients and gave them access to their care planning and risk assessments. The recovery star showed patients had been involved in identifying their own needs and goals. The

recovery star work then was incorporated into a care plan which was individualised.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Most patients had signed to say they understood and agreed with the content of their care plans.

Staff involved patients in decisions about the service, when appropriate. Care files showed that patients actively contributed and were offered a copy of their recovery star and care plans.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had daily morning meetings where they could suggest activities for that day. There were monthly regular community meetings where they could comment on the running of the hospital.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff supported patients to make decisions on their care. Patients routinely attended multidisciplinary team meetings to discuss their care and treatment and records showed their views were considered.

Staff made sure patients could access advocacy services. Information on advocacy services was displayed around the service. The advocacy service visited patients on request.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with three relatives. Family members were extremely positive about the quality of care their loved ones received at Millbrook. Family members told us that they were very confident and highly satisfied with the service. They felt listened to and stated there was great family involvement. Carers were encouraged to attend meetings such as ward rounds and care programme approach meetings via virtual platforms.

Staff helped families to give feedback on the service. Family members told us that staff were approachable and polite. They told us they received regular updates and staff were happy to talk to them. Staff respected patients decisions to refuse permission to pass on information about their progress to relatives, where appropriate.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Good

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

Access and discharge

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

Millbrook had 12 beds, and, at the time of the inspection, there were 12 patients. This gave a bed occupancy rate of 100% at the time of the inspection.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The median length of stay of patients at Millbrook for the current patients was 577 days, which amounted to approximately 19 months. This was within lengths of stay we would expect for patients with mental health rehabilitation needs within a community rehabilitation unit.

Many of the patients at Millbrook were admitted with significant mental health acuity and had significant rehabilitation needs. One long-term patient had been at the service for nearly four years at the time of inspection. They had been discharged but quickly relapsed and returned.

The service had no out-of-area placements. All of the current patients came from the local area. All of the beds at Millbrook were block purchased and paid for by the local clinical commissioning group as one of three NHS funded mental health rehabilitation units in Manchester city boundaries.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers and staff worked to make sure they did not discharge patients before they were ready. Records showed that six patients had been discharged from the hospital in the 12 months prior to the inspection. The service had successfully discharged a number of patients with complex needs successfully with good outcomes for these patients. This included patients who were rehabilitated and discharged into their own homes. Many of these patients were expected to go into some form of residential care when they were first admitted to Millbrook. One recently discharged patient had spent many years in other hospitals due to their acuity, lack of engagement and complex needs.

Staff did not move or discharge patients at night or very early in the morning. Moves and discharges were planned with the care co-ordinators and the patients. Two patients had well-established plans for their discharge and were expected to be discharged within the next three months. However, it had been difficult to fully engage the local care coordinators within local community mental health teams as part of some patients' discharge process. During the inspection, a patient's discharge meeting could not go ahead due to the care coordinator not attending the meeting. This was beyond the control of the hospital.

When patients went on leave there was always a bed available when they returned.

Patients were moved during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. On a very small number of occasions, staff asked that patients were returned to acute wards if their mental health significantly deteriorated, and they presented with significant management issues.

If patients deteriorated and could not be de-escalated, staff would look to transfer the patient to the nearby local mental health acute wards or psychiatric intensive care unit run by the local NHS mental health trust.

Discharge and transfers of care were well co-ordinated.

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. There were two patients considered as ready to move on and therefore deemed to be subject to a delayed discharge. The main reason for delays included shortage of suitable accommodation to move patients on to including awaiting social housing for those discharged into their own home. All of these were beyond the full control of the hospital, but staff had taken action with local providers and commissioners to try and reduce these delays. One of the support workers specialised in supporting patients to apply and bid for social housing and they liaised with the local housing team.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Managers met with senior leaders of the local rehabilitation services as part of the rehabilitation pathway to discuss patients who needed admission and those who were ready to move on. Staff also reported to commissioners and discussed delayed transfers of care and looked at what could be done to reduce these delays.

Staff supported patients when they were referred or transferred between services. Staff recorded regular, ongoing contact and communication with community mental health team professionals, including invitations to attend regular care programme approach meetings.

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. When clinically appropriate, staff supported patients to self-cater.

Long stay or rehabilitation mental health wards for working age adults

Good

Each patient had access to their own bedroom with an en-suite bathroom. Patients had access to their room 24 hours a day and could personalise their own rooms if they wished.

Patients had a secure place to store personal possessions. Each room had storage for patients to store their possessions as well as a separate lockable medicines storage for patients who had been assessed for self-medicating.

Staff used a full range of rooms and equipment to support treatment and care. This included a clinic room, multiple lounges, dining room, kitchens and quiet rooms.

The service had quiet areas and a room where patients could meet with visitors in private. There was a large lounge which was used for visiting. These had separate access from outside so carers could still visit while maintaining social distancing during the COVID-19 pandemic.

Patients could make phone calls in private. There was a payphone in a private booth for patients to make private phone calls. Patients could also have their own mobile phones, except if it had been risk assessed for individual patients on clinical or security grounds.

The service had an outside space that patients could access easily. Patients had direct and unlimited access to a large garden area. The gardens were well maintained and provided seating. There was a designated outdoor smoking area for patients to use. The occupational therapist had plans to plant in the raised beds and there was a poly-tunnel for growing plants and vegetables.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients could make their own hot and cold drinks at any time. Patients in the self-contained bedsits had a kitchenette where they could make meals and hot drinks.

The service offered a variety of good quality food. The provider had a centralised catering service and used a chill-cook system. In addition to the pre-prepared meals, kitchen staff were able to offer sandwiches, salads and light snacks on request. There was always both a meat and vegetarian option available. We did not receive any significant concerns from patients about the current quality of the food, other than some patients commenting on the smaller portion sizes not being to their liking. There was fresh fruit and healthy snacks available.

Many patients cooked meals as part of their rehabilitation through using either the communal kitchen or, for those in the bedsits, the kitchen in their rooms. Patients in the bedsits received a weekly allowance and were actively encouraged to buy and cook their own 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 opportunities for education and work, and supported patients. Patients had access to a detailed activities programme which was led by the occupational therapist. The activities available varied and were discussed at morning meetings to ensure patients maintained interest in the activities available; they included unit-based activities such as cooking, current affairs, crafts, relaxation, bingo and games; and outdoor activities identified on an individual basis such as college, walking groups, cinema, shopping trips and day trips. Millbrook had very good links with a local charity that provided support and learning opportunities including employability, functional skills, citizenship, and life skills in the community.

Staff helped patients to stay in contact with families and carers. Staff considered the timing and availability of local transport when discussing and agreeing patients going on leave to family members. Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Millbrook was a single storey building with wide access at the front to enable people who use a wheelchair easy access. There was an adapted toilet and bathroom for those patients with limited mobility. If additional aids or support were required, staff would source these on an individual basis for patients.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There were numerous display boards across the unit providing comprehensive information on a range of treatments, their rights as detained patients and local community facilities.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the cultural and dietary needs of individual patients. If patients required halal, kosher or other food to meet their specific needs this was ordered as required. There was always both a meat and vegetarian option available for patients.

Patients had access to spiritual, religious and cultural support. The unit was very close to a local church and had developed good links with it. Patients with religious needs were supported to attend community religious services as part of their integration back into the community in line with rehabilitation principles. The ward had a noticeboard informing patients of local church and religious services.

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 knew how to complain or raise concerns. Patients we spoke with understood their right to complain and felt confident that managers would look into complaints fully.

The service clearly displayed information about how to raise a concern in patient areas. The provider's complaints process and the CQC's involvement in handling complaints under the Mental Health Act were both advertised by posters in the ward's communal areas.

Staff understood the policy on complaints and knew how to handle them. Managers recorded informal concerns and complaints on an electronic database system. They could easily track the progress of any complaint.

Managers investigated complaints and identified themes. There had been no formal complaints made about this service in the previous 12 months up to the end of May 2022.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff knew how to acknowledge complaints. Staff we spoke with understood their role in supporting patients' rights to complain.

Managers shared feedback with staff and learning was used to improve the service. Staff encouraged patients to speak about any general concerns they had at the community meeting. Staff could deal with a problem quickly and reduce the need to formally complain.

The service used compliments to learn, celebrate success and improve the quality of care. There had been three compliments made about this service in the previous 12 months up to the end of May 2022.

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

Good

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

Leadership

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

The interim hospital manager had worked at Millbrook as the clinical nurse lead for many years. They had very good clinical oversight of the hospital while also being approachable to patients. Staff were complementary about the interim manager in terms of their approachability and recovery focus. The interim manager had recently made an application to be registered manager with us. Before this, there had been several interim managers in a row who usually also covered other hospitals run by the provider. Staff found the frequent changes of managers unsettling. Staff morale was reported to be improving now as a result of the interim hospital manager appointment.

The interim manager had a good understanding of the current issues about the running of the hospital as well as the legal frameworks such as the regulations we inspect against, the Mental Health Act and mental capacity legislation.

The interim manager was supported by an experienced interim clinical lead nurse who had worked as a nurse at Millbrook for a number of years. Senior managers were well cited on issues within the hospital and were working to address these.

Vision and strategy

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

Alternative Futures had the following vision and mission:

'A world where people control their lives. Together with our people and partners we will unlock skills, gifts and talents to support everyone's right to choose and achieve their aspirations.'

They had the following values:

- We are one.

Long stay or rehabilitation mental health wards for working age adults

Good

- We raise the bar.
- Every person matters.
- We make a positive difference.
- We take ownership.

The values were developed through a number of listening sessions for staff.

The interim manager had a vision for the model of mental health rehabilitation they wanted to provide, including reducing the average length of stay down to 12 months through adapting the rehabilitation programme. The team were developing local objectives.

Staff were committed to providing excellent, person-centred care.

Culture

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

Staff told us they felt well supported personally and professionally from the clinical lead nurse and interim manager. Staff told us that they received regular training and appraisal. Staff attended team meetings to ensure they were confident and competent in working with recovery based approaches with patients. We saw that changes had occurred following staff meetings.

Staff told us that they would recommend Millbrook as a place of work. Morale was very good.

There was information displayed in the hospital about how staff could raise concerns about people's care. Staff told us that they knew how to raise any issues through this process or anonymously.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level most of the time. Performance and risk were usually managed well with some shortfalls, usually relating to the recording of actions.

Alternative Futures had a computerised management system which assisted managers to understand what each hospital did well, and the actions required by registered managers to ensure good quality care to patients. It included information on incidents, safeguarding concerns, complaints and compliments. There were quarterly quality assurance meetings internally to discuss the findings from each hospital and ensure quality improvement measures were in place and working well.

The provider had an audit calendar which showed which audits needed to be completed. There was identified oversight of the audits. Results of these were discussed through quarterly local quality assurance meetings systems to flag up any delays in completing the audits as identified on the audit cycle. Staff completed clinical audits in line with the calendar.

Most audits were completed to a good standard. Following an incident last year where a patients' detention was not renewed, the provider had put in further systems to anticipate important dates that needed to be adhered to under the Mental Health Act.

Some monthly audits did not always clearly record what action had been taken to show that any identified shortfalls had been fully addressed. Each audit had a section to state what action was required and whether this had been completed. In a small number of cases this had not been completed fully to understand whether the action required had been addressed. For example, one of the regular Clozapine constipation audits showed that bowel movement monitoring was occuring to prevent the risk of patients' becoming constipated but that there were occasional lapses and it was not always happening daily as required by the provider' systems. The audit did not provide detail of what was being done to promote daily monitoring. Staff completed audits that looked at leave recording and review of consent to treatment but they did not identify the shortfalls we found and did not address them.

We found some shortfalls on the inspection which were not fully mitigated by the providers own systems. However, managers very quickly addressed these during or soon after the inspection. We found:

- The electricity cable was still in use contrary to the fire audit advice
- One patient did not have a personal evacuation plan in case of fire despite a recent poor response to a fire drill
- Managers had not ensured that a basic care plan or risk assessment was in place for one patient. They had not put contingency measures in places until the care plan and risk assessment records could be fully formulated such as through directing staff to where key information could be provided
- The provider did not notify us of one safeguarding incident that had been alerted to the local authority. The provider notified us during the inspection.

Managers had recently introduced a new computerised system to better record evidence that actions had been completed following audits. This was not yet fully embedded.

Management of risk, issues and performance

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

Staff maintained and had access to the service's risk register. Staff were able to escalate concerns when required.

Managers kept a risk register which identified risks to people or staff which were managed locally by managers and staff within the hospital. The current outstanding risks identified in May 2022 were:

- Qualified nurse vacancy rates.
- Patients going absent without leave.
- COVID-19 infections and its impact (including training uptake levels where training was required to be undertaken face-to-face).
- Patients smoking indoors against the hospital policy.
- One specific risk relating to an individual patient but which could compromise health and safety if not managed properly.

The risk register had details of how these risks could be mitigated and we saw that managers were making efforts to fully mitigate and improve in these areas.

The service had plans in place for emergencies such as adverse weather. The emergency plans had been reviewed following a major flooding incident at another of the provider's hospitals. This now included what

Long stay or rehabilitation mental health wards for working age adults

Good

Information management

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

Managers monitored a range of performance indicators through the electronic management system which provided information for incidents, care planning and risk assessments, and other key performance and safety data for the hospital.

Managers were providing detailed reports regularly with the local clinical commissioning group as part of their contract to provide NHS services.

Engagement

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

Managers regularly attended the rehabilitation meetings and rehabilitation pathway meetings with the local NHS mental health trust and other providers to look at which patients had been admitted and which were ready for rehabilitation. Staff regularly invited community mental health staff to ward rounds and care programme approach meetings and reported good working relationships.

Managers were meeting regularly with the local clinical commissioning group who oversaw the quality and safety of the service.

Learning, continuous improvement and innovation

Managers were introducing the 'safe wards' initiative which was a way of looking at every aspect of the hospital to ensure it was a positive experience for patients and help make it safer by reducing conflict and containment. Some of the 'safe wards' initiatives had been completed. For example, staff had completed mini-biographies which included their likes and dislikes which could be used as conversation starters and to break down barriers between patients and staff.

Managers were looking to reduce the average length of stay down to 12 months through adapting the rehabilitation programme.

There were no immediate plans for the hospital to be accredited with the Royal College of Psychiatry quality network for inpatient mental health rehabilitation services. The new interim manager had plans to benchmark the hospital against CQC's ratings characteristics to look at achieving an overall rating of outstanding.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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