Annesley House

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Annesley House as good because:

- We observed positive interactions between staff and patients.
- Patients had access to physical healthcare appointments and staff monitored patients' physical healthcare.
- Care plans and risk assessments were up to date and person centred and showed patient involvement. Patients and their families were involved in decisions about their care.
- Patients were supported to maintain their independence through real work opportunities and a variety of therapeutic activities facilitated by the occupational therapy team.
- The provider made sure there was the right amount of experienced staff to care for patients on all of the wards. Staff were inducted into the service, given regular supervision and appraisals and suitably trained.
- We saw evidence that showed all patients had access to individually tailored psychological treatments and were offered additional sessions if needed.
- Staff knew how to report incidents and we saw evidence that when this happened, managers shared the learning from these incidents with all staff.
- Staff morale had improved since the last inspection. Staff said they felt well supported by their managers and that change had been managed well throughout the service.
- There were effective systems in place to monitor key performance indicators for patient care and staff development.
- The hospital participated in national quality improvement programmes.

However:

- Not all staff were clear it was unsafe to access rooms that did not have a functioning alarm or nurse call system on a one-to-one basis with patients.
- Staff did not always implement individual risk assessments during periods of observation and this meant some staff were unclear as to how they should observe patients during the night if there was a risk they might harm themselves through hanging or strangulation.
- Staff were unsure about when and how often they should search a patient and their room.
- Some patients told us they did not feel supported by all staff on the ward and that the provider had not given them the opportunity to give feedback about the service.

Summary of findings

Contents

Good

Location name here

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Annesley House

Annesley House is an independent mental health hospital, which is part of the Priory Partnerships in Care group. The hospital was divided into three separate wards that aim to provide care, treatment and rehabilitation for up to 28 female patients with a primary diagnosis of mental illness and personality disorder.

Annesley House aims to provide a range of clinical therapies and individual treatment programmes for women detained under the Mental Health Act (1983).

Annesley House is a single building divided into three wards. Durham Ward is a nine bed low secure service. Cambridge Ward has 11 beds and is an admission ward.

Oxford Ward has eight beds and is a locked rehabilitation service. At the time of our inspection, there were 19 patients admitted to the hospital; six on Cambridge, five on Oxford and eight on Durham.

Annesley House was registered with CQC in 2010 to carry out the following regulated activities:

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

The hospital director was registered with the CQC as the registered manager. There have been eight inspections at Annesley House since registration with CQC; the last follow up inspection was on 17 July 2017.

Our inspection team

Team leader: Katie Lawson-King

The team that inspected the service comprised four CQC inspectors, two Experts by Experience and a psychologist specialist advisor.

Why we carried out this inspection

We inspected Annesley House because at our last inspection on 16 May 2017 we rated Annesley House overall as requires improvement. Following that inspection, we issued a warning notice to the provider as we identified a breach of Regulation 12 in relation to patient observations. We inspected Annesley House again on 17 July 2017 to follow up the warning notice. We saw that the provider had made the necessary improvements required.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service

Summary of this inspection

- spoke with two carers of people who were using the service
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with 20 other staff members; including doctors, nurses, occupational therapist, psychologist, psychology assistant, social worker and administrative and secretarial staff
- received feedback about the service from care co-ordinators or commissioners
- attended and observed a daily morning meeting, a multi-disciplinary meeting and a community meeting
- collected feedback from patients using comment cards
- looked at 12 care and treatment records of patients
- carried out a specific check of the medication management on wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Seven out of the nine patients we spoke with told us staff were kind, respectful and caring towards them. Two patients reported some staff talk down to them and sometimes make inappropriate comments.

Most patients reported feeling safe on the ward. The two patients who reported feeling unsafe on the ward told us this was because there was more male staff than female staff on night shifts and they felt there was a lack of communication between day and night staff.

Three patients told us that their community leave and activities on the ward were regularly cancelled due to a lack of staff.

All patients had received a copy of their care plan and all but one of the patients we spoke with had been involved in the development of their care plan.

All patients reported good access to advocacy and psychological therapy and felt involved in their treatment plans. Patients reported the food had improved since the employment of the new chef within the hospital and felt they had more choice over meals.

Two patients on Durham Ward did not understand why the provider only allowed patients to have 16 items of those listed as restricted items.

All patients knew how to complain. However, two patients and one carer said they had raised complaints and felt these complaints had not been investigated or they had not received any feedback/resolution.

One patient felt that staff took their community leave off them as punishment if they did not engage in meaningful therapeutic activities provided by the occupational therapy team and ward staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe improved. We rated safe as good because:

- Annesley House had a fully equipped clinic room with accessible resuscitation equipment. Staff checked emergency drugs regularly. Adequate medical cover was available day and night. In emergencies, a doctor could attend the ward quickly.
- Staff of different roles and grades knew when and how to report incidents and we saw evidence that they did so. The provider made improvements to its policies and procedures when things went wrong, demonstrating learning from incidents.
- Staff used the correct techniques to restrain patients, but did so only if efforts to calm them failed. The provider trained all staff in how to use restraint safely.
- Staff knew how to use seclusion in line with good practice. They assessed each patient carefully to determine their suitability for seclusion.
- The provider ensured wards had enough staff of the right grade to keep patients safe from avoidable harm. It used agency and bank staff in line with good practice and, wherever possible, filled shifts with those already familiar with the relevant ward.
- Staff followed good practice for managing and administering medication, including national guidance for rapid tranquilisation.
- The ward areas were clean and staff followed infection control principles.
- Staff understood how to protect adults and children from abuse and how to report to the local authority safeguarding team. The provider had safe procedures for children visiting the hospital.
- All staff had completed mandatory training, which was regularly updated.

However:

- Staff were unsure about when and how often they should search a patient and their room.
- Not all staff were clear it was unsafe to access rooms that did not have a functioning alarm or nurse call system on a one-to-one basis with patients.

Summary of this inspection

- Staff were unclear as to how they should observe patients during the night if there was a risk they might harm themselves through hanging or strangulation.
- Patients said their leave was regularly cancelled due to a lack of staff.

Are services effective?

Good

Our rating of effective improved. We rated effective as good because:

- Staff assessed the needs of patients and developed a care plan with each patient so all staff knew how to support them. Care plans showed clear evidence of patient involvement.
- Patients had a physical health examination on admission and staff monitored patients' physical health needs regularly. Patients had good access to physical healthcare and the local GP held a weekly clinic at the hospital.
- The provider offered all patients evidence-based psychological therapies to meet their needs. The provider offered all patients a range of evidence-based occupational therapy activities, tailored to their individual needs.
- Staff were engaged with clinical audit and used the findings from these audits to improve practice.
- The provider trained staff in the Mental Capacity Act and its guiding principles.
- The provider had ensured the full range of mental health disciplines were available and workers provided input to each of the wards. They worked together to provide treatment for the patients and ensure patients' needs were met.
- The provider had ensured all staff were regularly supervised and given annual appraisals. Staff had access to regular team meetings.
- The hospital worked well with the local authority safeguarding team, community mental health teams and clinical commissioning groups.

Are services caring?

Good

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

- We observed that staff were kind and respectful to patients. Patients told us staff were caring and responsive to their needs and we saw staff knew the individual needs of patients and how to support them.

Summary of this inspection

- Patients were involved in their care planning meetings, and the development of their care plans, and patients had a copy of these. Relatives and carers of patients were involved in their care where patients had agreed to this.
- The provider asked patients for their views in community meetings and feedback questionnaires and we saw actions were followed up to improve the service.
- Patients had access to real work opportunities, which encouraged patients to develop and maintain their independence as part of their therapeutic recovery.
- Patients had regular access to support to help them make their views and rights clear, in the form of advocacy workers.

However:

- Two patients told us they did not feel supported by all staff on the ward, particularly staff with whom they were not familiar.
- Three patients told us the provider had not given them the opportunity to give feedback about the service.

Are services responsive?

Good

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

- The provider ensured discharge was never delayed by the hospital or that patients were not moved between wards for anything other than clinical reasons.
- Patients always had access to a bed on return from leave.
- The provider ensured there were sufficient and appropriate rooms and equipment available on each of the wards to support care and treatment.
- Patients had access to their bedrooms and kitchens at all times. Staff developed contracts in collaboration with patients to outline how the keys were used in order to keep all of the patients on the ward and their belongings safe. Patients were able to personalise their bedrooms.
- Patients had access to quiet areas on the ward, outside space and a room where they could meet visitors. Patients were able to make a phone call in private in a separate room on the ward.
- Patients had access to a broad range of activities, including at weekends.
- The provider had ensured the food was of a good quality and several patients reported that this had greatly improved since our last inspection.

Summary of this inspection

- The provider had made appropriate adjustments for people requiring disabled access to the hospital.
- The provider ensured information leaflets were available in different languages spoken by the people using the service. Staff had completed work with patients around the Accessible Information Standard. The provider ensured there was information available for patients about treatments, local services, patients' rights and how to complain.
- The hospital had a multi-faith room for staff and patients to access and the provider gave patients access to appropriate spiritual support.

However:

- Not all care records included a note to say staff regularly discussed discharge with patients. Staff recorded that they had discussions with patients but not all included the patient's views.

Are services well-led?

Good

Our rating of well-led improved. We rated well led as good because:

- The provider had introduced systems to improve the governance within the hospital and these changes had been well implemented. There were effective systems in place to monitor key performance indicators for patient care and staff development.
- The hospital director had introduced a hospital development plan. This outlined the areas in which the hospital aimed to improve and the steps being taken to achieve these improvements.
- The provider ensured changes to the service were communicated effectively across the hospital. It had introduced feedback initiatives to gain the views of staff and encourage improvements.
- The provider ensured staff were supported to carry out their roles and were given the appropriate level of training and, where required, administrative support. Staff were given opportunities for leadership development.
- Staff reported morale had improved since our last inspection and that this was due to the support, structure and guidance provided by the senior management team.
- Staff knew and agreed with the values of the organisation and these values were embedded in the team objectives.
- Staff knew how to use the whistleblowing process.

Summary of this inspection

- The hospital was part of the RAID (reinforce appropriate, implode disruptive) Centre of Excellence for the Nottinghamshire region and took part in other national quality improvement programmes.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- The provider ensured effective systems were in place for monitoring detention renewals and Mental Health Review Tribunals by using a working dashboard to identify when updates/renewals were due.
- The service kept clear records of leave granted to patients. Patients, staff and carers (where applicable), were aware of the parameters of the leave granted, including individual risk and contingency plans and emergency contact and medical details, where appropriate.
- The service had a seclusion room and this met all of the requirements of the Mental Health Act Code of Practice.
- Ninety-four percent of staff had received training in the Mental Health Act within the last 12 months. Staff we spoke with were trained in and had a good understanding of the Mental Health Act, the Code of Practice. Staff adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable.
- Staff explained to patients their rights under the MHA on admission and every three months thereafter. Patients' Section 132 rights were available in an easy-read format.
- Administrative support and legal advice on implementation of the MHA and its Code of Practice was available from a central team and staff knew how to access this support.
- Staff filled in detention paperwork correctly and all paperwork was up to date and stored appropriately.
- We saw evidence of regular audits to ensure staff were applying the MHA correctly and learning from these audits was used effectively to encourage improvements.
- Patients had access to an independent mental health advocate (IMHA) and staff were clear on how to access and support engagement with the IMHA.
- The provider had a policy on MHA. However, this policy was not updated in line with the Code of Practice 2015 and made reference to outdated quotation from the 2008 Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to Mental Capacity Act and Deprivation of Liberty Safeguards.

- Ninety-five percent of staff had received training in the Mental Capacity Act (MCA) within the last 12 months and had a good understanding of Mental Capacity Act, in particular the five statutory principles.
- There were no Deprivation of Liberty Safeguards applications made in the last six months as all patients were detained under the Mental Health Act.
- There was a policy on MCA, which staff were aware of and could refer to.
- For patients who had impaired capacity, staff assessed and recorded capacity to consent appropriately. Staff did this on a decision-specific basis with regards to significant decisions, and patients were given every possible assistance to make a specific decision for themselves before staff assumed they lacked the mental capacity to make it.
- Staff supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in the patient's best interest.
- There were arrangements in place to monitor adherence to the MCA within the Trust and regular audits of MCA paperwork.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

- The layout of the wards at Annesley House did not allow staff to observe all parts of the ward. Bedrooms were out of view from staff. However, staff kept patients safe by adapting their observation levels to suit the needs and risks of the patient. For example, some patients who had a high risk of tying ligatures were observed at all times to keep them safe. The wards had convex mirrors to reduce blind spots and in some areas, the provider had installed closed-circuit television (CCTV) in communal areas to allow staff to observe patients at high clinical risk. The provider completed blind spot audits twice a year and we saw this had helped to reduce the number of blind spots and put appropriate mitigations in place where it was not possible to remove the blind spots.
- Ligature points were detailed in a comprehensive ligature risk assessment audit that the hospital's health and safety officer reviewed quarterly. A ligature audit is a document that identified places/objects to which patient intent on self-harm might tie something to strangle themselves. The provider had reduced the risks of ligature points by using anti-ligature fittings on taps, curtain rails and shower fittings.
- The provider completed regular environmental risk assessments. They ensured compliance with fire safety regulations via regular fire risk assessments with supporting action plans, which were complete. Quarterly fire door inspections, weekly fire drills and full evacuations biannually ensured staff knew what to do in case of a fire. Staff completed personal emergency evacuation plans for all patients.
- Annesley House had a fully equipped clinic room with accessible resuscitation equipment and staff checked emergency drugs regularly.
- The hospital had a seclusion room located on Cambridge Ward. This allowed clear observation, two-way communication, had toilet facilities and a clock, in compliance with the requirements of the Mental Health Act 1983 and Mental Health Act Code of Practice 2015.
- All ward areas were visibly clean, had appropriate furnishings and were well-maintained.
- Staff adhered to infection control principles throughout the hospital.
- Equipment was well-maintained, clean and stickers were visible and in date.
- There was access to appropriate alarms and nurse call systems throughout the hospital. The security lead on each shift tested the alarms before handing them to staff. At the time of our inspection, one therapy room on Oxford Ward did not give staff access to an alarm call system. This was clearly noted to all staff in staff meetings and daily morning meetings. A sign on the door of the room indicated staff must not use this room on a one-to-one basis with patients due to the risk of there being no alarm system. One staff member we spoke with was unclear on this and told us the use of

the room on a one-to-one basis with patients was determined by the patient's risk. However, all other staff we spoke with were clear on the guidance around using this room.

Safe staffing

- The provider had estimated the number and grade of nurses required and the number of nurses matched this on all shifts. Staffing levels had increased since our last comprehensive inspection in May 2016. Information provided by the registered manager showed that at 20 December 2017, there were 5.1 whole time equivalent (WTE) registered nurse vacancies, which worked out as 21.25% of the service's current registered nurse establishment. There were no care assistant vacancies in the hospital.
- The overall staff sickness rate at 30 September 2017 was 2.7%.
- There was appropriate use of agency and bank staff and these staff members were familiar with the ward and the patients. This ensured the staff member was familiar with the environment, the patients and their needs and clinical risks associated with the role. The provider aimed to have only one staff member on each shift who was unfamiliar with the ward and/or the patients. The provider had undertaken a number of recruitment initiatives in order to address the issue of qualified nurse recruitment, including relocation financial support, an established preceptorship programme and a return to nursing initiative on site. They had also increased the establishment of healthcare support workers in order to reduce reliance on agency staff.
- Ward managers were able to adjust staffing levels daily within the morning meeting to take account of case mix and increased/reduced risk. The hospital director and clinical services director also worked flexibly to support the staff team on site. We saw evidence and staff told us they both supported the team at weekends and evenings where additional support was required. There was a shift co-ordinator and senior manager on call for every shift and out of hours a senior nurse was on-call for the region. A night services manager covered the region during night shifts.
- Staff who were allocated to one-to-one observations were allocated in addition to the main staffing establishment.
- Staff told us and we saw a qualified nurse was present in communal areas on each of the wards at all times.
- The provider ensured there was enough staff to allow patients to have regular one-to-one time with their named nurse/care co-ordinator. There were enough staff to safely carry out physical interventions when required. These were discussed as a team and planned to be as least restrictive as possible when appropriate. Ward managers completed one 0.5 whole time equivalent (WTE) clinical shift per week.
- Four out of nine patients we spoke with told us leave was regularly cancelled due to there not being enough staff to facilitate this. During a six month period up until our inspection, Cambridge Ward had six hours of cancelled Section 17 leave, Oxford Ward had 14 hours of Section 17 Leave cancelled and Durham Ward had 23 hours of Section 17 leave cancelled. This was either due to late sickness, staffing levels or an increase in observations. The provider ensured all leave was facilitated in collaboration with the patient either later in the day or the next day.
- The provider ensured there was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. One out of hours consultant psychiatrist covered the five sites within the region and was based at Calverton Hill. In case of a physical health emergency out of hours, the nurse in charge was responsible for calling the consultant out of hours to determine what action to take.
- The provider ensured staff received and were up to date with appropriate mandatory training. The average mandatory training rate for staff was 96%.

Assessing and managing risk to patients and staff

- During our inspection visit, we reviewed 12 care and treatment records (five from Durham Ward, four from Cambridge Ward and three from Oxford Ward). The records we reviewed showed that staff undertook a risk assessment of every patient on admission and staff updated these regularly, including after every incident.
- Staff had recently begun using a new risk assessment screening tool created by the provider. This allowed staff to review patient's immediate risk regularly following changes in behaviour or risk. The ward manager on Oxford Ward had developed a poster, which gave staff guidance on how to use the new process. In addition to this tool, staff used the Short Term Assessment of Risk and Treatability (START) and the Historical Clinical Risk Management-20 version 3 (HCR-20v3) to assess and

monitor patients' risk. Staff completed these risk assessments on each patient's admission (where a history of violence was present) and then every six months thereafter.

- Patients were restricted as to how many items they were able to keep in their bedroom. Individual risk assessments were made for these restrictions.
- Staff and patients appeared to confuse high-risk items (such as cutlery or razors) with contraband (such as illegal substances or cigarettes) and restricted items (such as high-calorie sugar-based snacks and chocolate). For example, on Durham Ward, patients and staff we spoke with explained that patients were able to keep 16 items of those listed as restricted items on their person or in their bedroom. On Cambridge Ward, staff and patients were unclear on how many items patients were able to have on their person or in their bedroom, but told us there were restrictions. On Oxford Ward, staff told us patients were able to have 20 items of those listed as restricted and that this had been decided in conjunction with patients. Patients we spoke with were not clear on why these restrictions were in place and did not feel staff had consulted them when staff made this decision. Staff told us the purpose of these restrictions was to encourage patients to engage in therapeutic activity, to avoid storing more items than they needed at one time due to this presenting as a potential fire hazard and to help patients to manage their weight. Staff and patients told us and we saw that patients were able to keep additional items in locked cupboards in the kitchen and could access these items upon request from staff. We saw in meeting minutes that staff and patients discussed restricted items during the least restrictive practice meeting, but the rationale behind these restricted items remained unclear.
- The provider had implemented new policies and procedures for the use of observation and these had continued to improve since our last inspection. We reviewed the observation records for one patient for October 2017. These were all complete and accurate in line with the patient's care plan. Observation records were detailed, clear and recorded in real time.
- The provider had implemented additional checks of observations forms to ensure staff were completing these correctly. For example, for the three months after the new observation policy was introduced in May 2017, ward managers completed daily audits of the observation records. These audits were then reduced to weekly. Any issues raised in the audit were addressed in supervision and this information was attached to the audit for regular review. Monthly 'quality walk arounds' were also in place to review environmental risk and patient documentation.
- During our inspection, we reviewed an incident in which a patient who had a known history of tying ligatures alleged to have tied a ligature around their neck during the night. Although the patient was unharmed the following day, there was no evidence to indicate that staff had checked the patient's neck during the night, as indicated by some staff reports. Staff reported they had checked for signs of life and observed the patient to be sleeping, as per the observation policy, but there was no written evidence of staff checking the patient's neck for ligatures. Staff we spoke with were unclear as to how patients should be observed during the night if there was a risk of ligature. This suggests patients' observation requirements did not align with their individual risk assessment needs. We raised this with the staff team and during our feedback. The provider agreed this presented a serious risk to patients. We have received assurance from the hospital director that staff would ensure this was documented on the observation record that checks on patients who are in bed and are at risk of tying a ligature include that the neck area has been checked.
- At the hospital reception, there was a button, which staff, patients and visitors pressed on entering and this signalled if a random search was needed. Staff completed additional searches on patients based on each patient's individual risk assessment. There was some inconsistency in the responses from staff about when and how frequently pat down searches and room searches were carried out. However, it was clear that searches were based on an individual's risk assessment and consent was obtained where possible.
- Restraint was only used after de-escalation had failed and 97% of staff were up to date with their management of violence and aggression (MVA) training.
- The use of rapid tranquilisation followed National Institute for Health and Care Excellence (NICE) guidance. The provider completed a monthly tracker of rapid tranquilisation. All patients who received rapid tranquilisation received physical health monitoring as

set out in the policy within the timescales stipulated. The tracker was used to record all rapid tranquilisation and the review of this was added to the morning meeting agenda for discussion and monitoring.

- Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. There were 14 incidents of seclusion at the hospital in the last six months up until 30 September 2017. During our inspection visit, we reviewed eight seclusion records for four different patients from Cambridge Ward from June to December 2017. Seclusion was used appropriately, reviewed according to the Code of Practice (2015) and the records were kept in an appropriate manner.
- Long-term segregation is where, in order to reduce a sustained risk of harm posed by the patient to others, a multi-disciplinary review and a representative from the responsible commissioning authority decides that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. However, patients should not be isolated from contact with staff or deprived of access to therapeutic interventions. There was one incident of long term-segregation in the last six months up to 30 September 2017, which took place on Cambridge Ward. Long-term segregation was monitored carefully in accordance with the Mental Health Act Code of Practice.
- The provider had trained 94% of staff in safeguarding adults level 2 and all staff in safeguarding children level 2. The provider had trained all of the safeguarding trainers in safeguarding adults and children level 3. Staff we spoke with knew how to make a safeguarding alert or referral and sought advice from the social work team where appropriate to support with this. The provider identified one staff member as the safeguarding contact for every shift to make sure staff knew who to contact for queries. All wards had a flow chart in the office for the procedure for making a safeguarding alert or referral and the contact details for the multi-agency safeguarding hub (MASH). Staff also discussed any safeguarding issues/concerns in morning meetings and multi-disciplinary team meetings and were clear on how to manage the immediate risk to the patients until further action could be taken. The social work and safeguarding team had produced a presentation for patients to help them to understand what safeguarding was.
- There were safe procedures for children visiting the hospital. The social work team reviewed patients' requests for children to visit them and completed child visiting access assessments. There was a separate room in the main corridor of the hospital for patients to have visits from children. This room was child-friendly in its décor and had CCTV fitted for the safety of child visitors. Children were unable to access the ward.
- The provider ensured there was good medicines management practice throughout the hospital. All new nurses were subject to a competency assessment before administering medication and staff completed clinic audits daily. Upon reviewing the medication kept on site, we noted that although everything was labelled safely, there was some confusion around some items being labelled as 'opened' when not required. This was because they were tablets that had been sealed and dated by the manufacturer. We raised this with the hospital director and other senior leads during our inspection. The Director of Clinical Services scheduled a meeting with the pharmacist to discuss this and gain clarity before sharing the findings with the registered nurses across site via supervision and colleague meetings. The confusion over this labelling did not present a risk to patient safety.
- The hospital was non-smoking and offered a 12 week smoking cessation programme supported by the physical healthcare lead and local GPs.
- Staff ensured therapeutic activities/sessions were appropriately risk-assessed to ensure the safety of all patients and staff. For example, in the occupational therapy department, we saw equipment was signed in and out and kitchen equipment was checked daily to ensure everything was accounted for. In addition, therapeutic activities were discussed in daily morning meetings to make sure the risk level remained the same and that the risk could be safely managed.

Track record on safety

- Annesley House reported four serious incidents during the 12-month period prior to this inspection (December 2016 – December 2017). The service had made significant improvements to their policies and procedures following a serious incident in 2017 involving a death due to self-ligation. The most

Long stay/rehabilitation mental health wards for working age adults

Good

significant improvement the service had made was in its observation and engagement policy and the ongoing monitoring and review of staff's compliance with this policy.

- Staff described some of the recent improvements within the hospital as a result of incidents. Improvements included regular ward managers meetings and a large scale review of all meeting agendas to ensure appropriate actions were being addressed and shared accordingly across the staff team.

Reporting incidents and learning from when things go wrong

- All staff knew when and how to report incidents and we saw evidence that staff of different roles and grades reported incidents. Staff recorded incidents on an electronic system.. This was accessible from any computer for any staff member to be able to report incidents. Ward managers and multi-disciplinary leads reviewed incidents from the previous shifts at the morning meeting and then reviewed via dashboards to monitor trends, investigate where required and plan preventative and remedial action.
- We saw evidence that staff were open and transparent with patients and explained when things went wrong. Staff gave examples of when this had happened and how the team reviewed the incidents and put plans in place to prevent them from recurring in the future.
- Staff received feedback from the investigation of incidents both internal and external to the service via team incident review (TIR) meetings. All staff involved in the patient's care at the time of the incident were invited to this meeting and lessons learnt shared. This information was then cascaded across all hospitals and reviewed in clinical governance meetings, alongside graphs showing trends as to when and why incidents occurred. In addition, a bullet pointed sheet was emailed to staff and put in the folders on each ward to share learning from incidents. Staff also reported learning was shared through supervision, reflective practice and staff meetings. Reflective practice is the ability to reflect on one's actions so as to engage in a process of continuous learning. Staff received formal reflective practice sessions every six weeks from the psychologist. All staff meetings had 'lessons learned' as part of the regular agenda to encourage discussion around this at every meeting.
- Staff were offered a debrief and additional support following serious incidents. We saw evidence of this having taken place following serious incidents.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- During our inspection visit, we reviewed 12 care and treatment records (five from Durham Ward, four from Cambridge Ward and three from Oxford Ward). These showed that staff completed a comprehensive and timely assessment of each patient following their admission. This assessment included a detailed description of the patient's mental health and physical health needs and recommendations for treatment were clear. Records reviewed showed evidence of ongoing monitoring of physical health problems, including separate care plans for these needs where appropriate. Staff also reviewed patients' physical health needs during multi-disciplinary team review meetings. All care records reviewed were up to date, personalised, holistic and showed clear evidence of patient involvement. Care plans were recovery oriented and contained information about each patient's strengths and goals and plan for recovery.
- We noted in records reviewed that the same named nurse, responsible clinician and social worker for each patient had uploaded each of the reports to the electronic recording system. This demonstrated good continuity of care for the patients.
- All information needed to deliver care was stored securely, in an accessible form and available to staff when they needed it.

Best practice in treatment and care

- Staff followed National Institute for Health and Clinical Excellence (NICE) guidance when prescribing medication. Ashton's pharmacy provided pharmacological input to the hospital and visited weekly to ensure staff administered medication in compliance with NICE guidelines.

Long stay/rehabilitation mental health wards for working age adults

Good

- The psychology department offered a range of psychological therapies as recommended by NICE. The psychology team completed an initial assessment of patients within 12 weeks of their admission. This included a range of different clinical assessments including the Psychological Inventory of Criminal Thinking Styles, Clinical Outcomes in Routine Evaluation, Brief Symptom Inventory and the Historical Clinical Risk Management-20 version 3 (HCR-20v3). Following this comprehensive assessment, the team devised a treatment pathway in conjunction with the patient, based on their individual need and risk. Treatment options offered include Dialectical Behaviour Therapy (DBT), Schema therapy, Cognitive Behavioural Therapy (CBT) and a range of skills groups. Staff discussed patients' treatment plans in multi-disciplinary team meetings and reviewed individual needs. Psychology staff recorded all session notes and care plans relating to psychological treatments on individual patients' electronic care plans. Patients reported the psychological interventions offered to them were tailored to their needs and helpful to their recovery.
- The psychology team developed positive behaviour support plans with each patient. The aim of these plans was to enable patients and staff to work together to de-escalate risk and encourage positive behaviour.
- Patients had good access to physical healthcare, including access to specialists when required. The hospital had good links with the local GP service and patients were able to attend appointments as and when required. The GP held a weekly clinic there. The hospital had a regional physical health nurse who attended the hospital for one day each week and liaised closely with the GP. GPs completed annual physical health checks for all patients. One healthcare worker was trained as a physical care coordinator and acted as the infection prevention control lead. The provider had trained the physical care coordinator in phlebotomy, wound care and first aid. The physical care coordinator completed a healthy living passport for each patient. The healthy living passports focused on health and exercise for the upcoming week. A dietician attended the hospital monthly and access to dentists and opticians was available as and when required. The hospital reported good working relationships with the local physical healthcare hospital, Kings Mill Hospital.
- The hospital had a well-established occupational therapy department. The occupational therapy (OT) team consisted of qualified occupational therapists, recovery workers, sports instructors and technical instructors. OT's provided assessment and specialist therapeutic groups and interventions. Technical instructors provided specialist interventions such as sports, education, crafts and supporting real work roles. The recovery workers were a new addition to the team and facilitated community-based programmes. The addition of recovery workers to the department allowed the team to develop a more graded, comprehensive activity programme. The evidence-based Model of Human Occupation model of treatment underpinned the OT treatment offered. The OT team completed a range of assessments within the first three months of a patient's admission to the hospital, including the Model of Human Occupation Screening Tool (MOHOST), the Occupation Self-Assessment (OSA) and met with each patient to complete a goal setting session. The team then developed individualised therapeutic timetables for each patient and each patient had a copy of their own timetable. The OT department offered patients a range of OT groups and individual sessions. OT staff recorded all session plans and interventions on each patient's individual electronic care plan. The OT department recently had training in sensory integration, which allowed the team to include patients' sensory needs in understanding and formulating their behaviour.
- Staff used recognised rating scales to assess and record severity and outcomes, including Health of the Nation Outcome Scales (HoNOS) and HoNOS Secure.
- The provider had introduced a 'least restrictive practice' steering group. Least restrictive practice was on the agenda at community meetings for patients and staff to discuss together. We saw several examples of the provider implementing the least restrictive practice whilst keeping patients safe.
- Clinical staff participated actively in clinical audit. A divisional audit calendar encouraged staff to examine a range of practices throughout the year. These included infection prevention control, safeguarding, Mental Health Act and managing violence and aggression (MVA). The provider shared these audits with senior staff and actions were clearly identified to encourage improvement. In addition, the provider had introduced monthly quality walk rounds. Staff from other wards completed these quality walk rounds. Staff members completing the walk rounds then fed this back to the

corresponding ward manager. The ward manager was then responsible for actioning the identified improvements. Staff fed the findings from these audits into specialised groups for action. For example, ward managers carried out restrictive practice audits on each of the wards and fed their findings back to the restrictive practice steering group.

Skilled staff to deliver care

- The provider ensured the full range of mental health disciplines and workers provided input to the ward, including; consultant psychiatrists, psychologists, assistant psychologists, social workers, occupational therapists, recovery workers, technical instructors, nurses and health care support workers.
- The provider ensured staff were experienced and suitably qualified.
- Staff received an appropriate induction, which covered their mandatory training programme. Agency, bank, locum and new staff were required to complete a hospital and ward-based induction before working independently on any of the wards. All health care support workers were required to complete the Care Certificate in addition to the provider's induction training schedule.
- Staff were given regular supervision and annual appraisals. Staff combined clinical and managerial supervision and accessed this monthly. As at 30 September 2017, the percentage of non-medical staff who had received supervision on a monthly basis was 95%. Staff told us that ad-hoc supervision was also available as and when they needed it. The percentage of non-medical staff that had an appraisal in the last 12 months was 73%. The provider was in the process of changing their appraisals to bring them into line with the Priory Group system. Under the Priory Group system, all appraisals will be done in the first three months of each year. Therefore, given the date of our inspection, these will be brought up to date between January and March 2018.
- Staff had access to regular team meetings. Staff attended monthly meetings for their discipline (i.e. psychology meeting, social work meeting). Ward staff attended one of two staff meetings offered monthly to cover all shift patterns. The provider held clinical governance meetings monthly and regional physical healthcare meetings quarterly.
- Staff received the necessary specialist training for their role and were given a range of opportunities to complete further training upon request. For example, the provider now offered eating disorder awareness training, which was delivered by Cheadle Royal Specialist Eating Disorder ward. Autistic Spectrum Disorder awareness training was also available to staff. A ward manager, occupational therapist and staff nurse we spoke with told us the provider had given them the opportunity to complete their Dialectical Behaviour Therapy (DBT) training.
- Managers addressed poor staff performance promptly and effectively. Managers developed performance improvement plans for staff requiring additional support with their role. Managerial staff were clear on the processes for addressing poor staff performance and we saw evidence of how managers liaised with human resources team where required.

Multi-disciplinary and inter-agency team work

- Staff attended fortnightly multi-disciplinary meetings. In addition, the provider held individual care review meetings on alternative weeks to multi-disciplinary team meetings to ensure staff reviewed patients' needs regularly. Professional leads and ward managers attended daily morning meetings. These gave staff an opportunity to share what had happened the previous day and the plans for the coming day, as well as review staffing, leave, observations, medication and ward dynamics and activities. One healthcare support worker told us they thought healthcare support workers should be invited to attend multi-disciplinary team meetings.
- All ward staff attended handover meetings between each shift.
- There were effective working relationships with other teams both within and outside of the organisation. Staff reported positive working relationships with local GPs, local authority social services and local community mental health teams. The staff team had developed their working relationships with local clinical commissioning groups by setting up monthly engagement meetings and providing regular clinical updates.

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

Long stay/rehabilitation mental health wards for working age adults

Good

- The hospital's Mental Health Act administrator examined Mental Health Act papers on admission.
- Staff knew who the Mental Health Act administrator was and they offered staff support to make sure the Act was followed in relation to renewals, consent to treatment and appeals to detention. The provider ensured effective systems were in place for monitoring detention renewals and Mental Health Review Tribunals by using a working dashboard to identify when updates/renewals were due.
- The service kept clear records of leave granted to patients. Patients, staff and carers (where applicable), were aware of the parameters of the leave granted, including individual risk and contingency plans and emergency contact and medical details, where appropriate. Staff had access to a quick view "current active leave authorisations" on each patient's electronic recording system. This meant staff could quickly access the most up to date leave for each patient without having to check through previous leave authorisations.
- Ninety-four percent of staff had received training in the Mental Health Act within the last 12 months. Staff we spoke with were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable. This meant that the staff member administering the patient's medication was able to do so under the correct legal status in respect of each patient's consent to treatment.
- Staff explained to patients their rights under the Mental Health Act on admission and every three months thereafter. Patients' section 132 rights were available in an easy-read format.
- Administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice was available from a central team and staff knew how to access this support. The Mental Health Act administrator attended quarterly meetings with a group of Mental Health Act administrators from local NHS and independent healthcare organisations to provide support and get updates regarding the Code of Practice. The provider supported the Mental Health Act administrator to attend these meetings.
- Staff filled in detention paperwork correctly and all paperwork was up to date and stored appropriately.
- We saw evidence of regular audits to ensure staff were applying the Mental Health Act correctly and learning from these audits was used effectively to encourage improvements. The last Mental Health Act audit the service completed was in August 2017.
- Patients had access to an independent mental health advocate (IMHA) and staff were clear on how to access and support engagement with the IMHA.

Good practice in applying the Mental Capacity Act

- Ninety-five of staff had receiving training the Mental Capacity Act within the last 12 months.
- There were no Deprivation of Liberty Safeguards applications made in the last six months as all patients were detained under the Mental Health Act.
- Staff we spoke with were trained in and had a good understanding of Mental Capacity Act, in particular the five statutory principles.
- There was a policy on Mental Capacity Act, which staff were aware of and could refer to.
- For patients who had impaired capacity, staff assessed and recorded capacity to consent appropriately. Staff did this on a decision-specific basis about significant decisions, and patients were given every possible assistance to make a specific decision for themselves before staff assumed they lacked the mental capacity to make it.
- Staff supported patients to make decisions where appropriate and when they lacked capacity, staff made decisions in the patient's best interest. Staff took into account the person's wishes, feelings, culture and history.
- Staff knew where to get advice regarding Mental Capacity Act within the company.
- There were arrangements in place to monitor adherence to the Mental Capacity Act within the Trust and regular audits of Mental Capacity Act paperwork.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Good

Kindness, dignity, respect and support

- On all three wards, we saw a number of examples of staff interacting with patients on a professional yet friendly and supportive manner. We saw patients and staff laughing together and staff responded to patients efficiently and quickly.
- Staff respected patients' dignity, for example, staff knocked on patients' bedroom doors before entering.
- Seven out of the nine patients we spoke with said staff treated them with respect and supported them to feel safe on the ward. They told us staff spent time with them on the ward and they always had access to staff members when they needed them. For example, one patient told us of an occasion where they had struggled to sleep due to feeling low in mood. They described how a staff member had sat with them and talked to them until they fell asleep. Two patients told us they did not feel supported by all staff on the ward, particularly staff with whom they were not familiar.
- Patients reported they were offered choice in activities and treatments and talked positively about the nursing and multi-disciplinary team in supporting them with a range of activities.
- Staff were heavily involved in activities with patients and had a good knowledge of the patients with which they were working.

The involvement of people in the care they receive

- The admission process informed and oriented new patients to the ward and the service. Upon admission, staff supported patients on a one-to-one basis until the patient had been fully admitted to the ward. Patients were given an orientation welcome pack, which provided them with information about the service and the ward to which they had been admitted. Staff also offered newly admitted patients the opportunity to have a 'buddy' on the ward. The buddy was another patient that would support them in their first few days/weeks of admission in getting used to the new environment. The service had a clear process for patients to meet with their multi-disciplinary team in the first two days of their admission.
- Patients were actively involved in their care planning, including discharge planning, and had access to a copy of their care plans. Staff had developed a 'signing in' sheet, which the patient signed to say they had been involved in any updates to their care plans. We saw evidence that patients actively participated in the development and review of their care plans.
- Staff invited patients to attend regular multi-disciplinary team meetings to discuss their progress. On the day of our inspection, the psychiatrist was unable to attend the review meeting and this led to patients not wanting to attend their meeting due to not being able to gain definitive answers to their requests. However, staff were kind and reassuring towards the patients and listened to patients' requests before explaining how they would pass these on to the psychiatrist in order to resolve any issues. Patients were invited to attend the service development clinical governance meeting to make sure the patient voice was represented.
- With patient consent, members of the social work staff team contacted patients' next of kin/carer during the patient's first week of admission to the hospital. The social work team then followed this up with a letter to ask the patient's next of kin/carer how they would like to be kept informed of the patient's progress. A carer's newsletter was sent out to patients' carers with their consent. Staff encouraged patients' families/carers to attend Care Programme Approach meetings and regular multi-disciplinary team review meetings. The social work team told us the hospital was able to financially support families to attend. With patient consent, members of the social work team made contact with carers prior to a patient's Care Programme Approach meeting in order to gather their views on the patient's current and proposed treatment plan. A separate feedback form, in addition to contact with social workers, had been introduced and was posted to carers prior to Care Programme Approach meetings to further encourage feedback.

Long stay/rehabilitation mental health wards for working age adults

Good

- Fortnightly community meetings were held on each of the wards. These were well-attended and addressed issues raised by patients. We saw evidence that concerns raised by patients were addressed and actioned appropriately.
- The provider circulated a patient newsletter to patients regularly and in November 2017, the patient alliance group was relaunched. Patients completed a patient satisfaction survey in May 2017 and we saw staff had developed a comprehensive action plan to improve patient satisfaction.
- Patients had regular access to advocacy, provided by an external advocacy service. The advocate attended the hospital for one day a week and was available to attend independent care review meetings when requested to do so. The provider also gave patients the option to use an advocate from a previous placement if they wanted to.
- Staff encouraged patients to maintain their independence. One of the ways in which staff did this was by providing access to real work opportunities. These activities enabled patients to gain new skills, responsibility and earn money. Some of the real work opportunities available were library assistant, nail technician, domestic assistant and mindfulness group lead. Oxford Ward was self-catering, which meant that the patients did their own food shopping (this was funded by the hospital). This encouraged patients to develop their independence skills and this functioned as part of each patient's discharge planning. The hospital advocated positive and therapeutic risk taking to make sure that patients were prepared for risks in the environment when moving on. We saw several examples of how the hospital promoted positive risk taking effectively. For example, the hospital supported one patient financially to receive their medication on site during long-term home leave. This supported the patient's independence and recovery.
- Patients told us and we saw the social work team and the nursing team liaised with patients' families to keep them updated on any progress/changes to the patient's care and treatment.
- We received a mixture of feedback from patients about whether they were able to give feedback about the service they received or were involved in decisions about the service. Three of the nine patients we spoke with told us the provider had not given them an opportunity to give feedback about the service they received or to contribute to decisions about the service. None of the patients we spoke with gave us any examples of how they had been involved in service development.

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

Good

Access and discharge

- Average bed occupancy over the last six months (up to 30 September 2017) was 68%.
- Annesley House is a national service and therefore has no local catchment area. All patients are referred by local Commissioning Teams and some may be placed out of area.
- Patients always had access to a bed on return from leave.
- The provider did not move patients between wards during an admission unless this was justified on clinical grounds and was in the interests of the patient. When patients were moved or discharged this happened at an appropriate time of day and was planned for in advance to reduce disruption as much as possible.
- The provider kept a bed open on Cambridge Ward (high dependency unit) in case a patient from Oxford Ward required more intensive care. Patients from Oxford Ward had the option to sleep in this additional bedroom if they were acutely unwell and wanted access to a different space.
- Discharge was never delayed by the hospital for any reason other than clinical reasons. However, the provider reported long delays to approve section 17 leave and transfers/discharges for patients under Ministry of Justice (MOJ) restrictions (primarily on Durham Ward). For example, for one patient, the provider applied to the MOJ for section 17 leave in May 2017 and the leave was not granted until December 2017. Such delays in granting leave impacted on patients' transfers and discharges. This is a national issue and the provider told us patients' solicitors were

challenging these delays. The hospital's Mental Health Act administrator emailed the MOJ weekly to follow up these delays. These figures were also reported through the monthly safety thermometer and weekly updates were sent to local commissioners.

- We saw evidence of discharge planning in two of the 12 patient notes we reviewed. For example, staff had outlined who would assess the patient for discharge, when this would be done, what the next stage would be and a discharge "action plan" was drawn up when the patient accepted their next placement. However, Staff recorded patients' views on discharge separately but this information did not feed into a wider discharge plan.

The facilities promote recovery, comfort, dignity and confidentiality

- The full range of rooms and equipment to support treatment and care were available on each of the wards. Each ward had a clinic room, a kitchen, individual therapy rooms and the hospital had additional therapy spaces available for patients from all wards to use, including a gym, library, computer room and a salon. Each ward area felt welcoming, homely and comfortable.
- Patients had access to their bedrooms and kitchens at all times. On Oxford Ward, all patients had keys for their bedroom and kitchen. Staff developed contracts in collaboration with patients to outline how these keys were used in order to keep all of the patients on the ward and their belongings safe. Some patients were risk assessed to require supervision in accessing their bedrooms and the kitchen, but this access was facilitated by a one-to-one supporting staff member as required.
- Patients had access to quiet areas on the ward and a room where they could meet visitors. Patients were able to make a phone call in private in a separate room on the ward. Staff completed risk assessments for each patient to determine whether they were safe to have access to their own mobile phone. On Durham Ward, patients did not have access to their own mobile phones between the hours of 22:00 and 8:00 due to the restrictions applied in a low secure environment. However, patients had access to the ward landline phone at all times.
- Patients had access to outside space. Each of the wards had an enclosed secure outdoor space which patients had access to at all times. The outdoor space was well-maintained and suitable for purpose.
- The food was of a good quality and several patients reported that this had greatly improved since our last inspection. Cambridge Ward had introduced a food feedback book in response to historical complaints about food. This allowed patients to express their opinions about the quality of the food and had reduced the number of complaints about food.
- Patients were able to make hot drinks and snacks at all times. On Cambridge Ward, staff had removed the kettle in the kitchen in response to an incident in which a patient had scalded a staff member with hot water from the kettle. The provider replaced this kettle with an instant hot water dispenser. However, several patients raised this as an issue and this was discussed and reviewed in the patient-led community meeting.
- Patients were able to personalise their bedrooms and we saw patients had posters and pictures on display around their bedrooms and on their bedroom doors.
- Patients had access to a broad range of activities, including at weekends. The hospital introduced a 'structured day' timetable for each patient from Monday to Friday. This meant organised activities were set up at specific times to encourage patients to develop structure and routine in their day, as part of their therapeutic recovery in preparation for discharge. These activities included; cooking group, dog walking, choir, arts and crafts, book club and individual therapy and goal-setting sessions. The patient choir was awarded the National Service User Award in 2017. Several patients were engaged in an activity called 'craft for causes'. This was developed to encourage patients to select a charity for which they would make products. At weekends, ward staff provided social activities such as board games and movie nights. The hospital encouraged patients to access community leave at weekends.

Meeting the needs of all people who use the service

- The provider had made appropriate adjustments for people requiring disabled access to the hospital. Ramp access to the building had been widened to ensure easy access for an emergency team. This was put in place following an incident in which a person was taken out of the building on a stretcher and staff found the corners of

the ramp difficult to navigate due to their narrowness. There was access to a lift and all showers rooms were wet rooms, allowing disabled access. All of the bedroom doors were able to facilitate wheelchair access and opened either inward or outward for ease of ingress and egress. The provider was planning a further refurbishment of the wards to further upgrade this facility.

- The provider ensured information leaflets were available in different languages spoken by the people using the service. Staff had completed work with patients around the Accessible Information Standard. The Accessible Information Standard applies to people using the service (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, deafblind and/or who have a learning disability. Plus, people who have aphasia, autism or a mental health condition which affects their ability to communicate. The occupational therapy team completed sensory and communication assessments of patients' needs where required and provided information in an easy-read format where appropriate. We saw information in pictorial format throughout the hospital and communication passports to support patients with these communication needs. The psychology team also provided printed information for patients with problems with their short-term memory to aid recall of sessions.
- The provider ensured there was information available for patients about treatments, local services, patients' rights and how to complain. Information about complaints was displayed around the hospital and on the wards and patients we spoke with were aware of this.
- The provider accessed interpreters and/or signers as required via the provider headquarters.
- Patients were offered a choice of food to meet their individual dietary requirements. However, one patient told us that there was only vegetarian option available at each meal and when special meals were on offer, there was no vegetarian option.
- The hospital had a multi-faith room for staff and patients to access and patients were given access to appropriate spiritual support. Records we reviewed showed that staff routinely asked patients if they wished to access a pastor of their faith and had the facilities to support this. One patient attended a local Church in Annesley.

Listening to and learning from concerns and complaints

- Patients knew how to complain and when patients did complain they received feedback. We saw posters around the wards detailing how patients could raise complaints including an easy-read complaints leaflet. We reviewed two complaints raised between May and November 2017. In both of these, staff followed a clear process for handling the complaint and resolution was sought. Staff reviewed complaints and compliments daily at the morning meeting. The complaints manager held a database of complaints made and a record of actions taken.
- Staff received feedback on the outcome of the investigation of complaints through staff meetings, supervision sessions and appraisals. Senior leaders shared the outcome of complaint investigations in clinical governance meetings and themes and trends were cascaded via the ward managers to ward staff, where appropriate.

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

Good

Vision and values

- The values of The Priory Group were "putting people first, being a family, acting with integrity, striving for excellence and being positive". Staff knew and agreed with the organisation's values and these values were embedded in the team objectives. Staff told us how the values were developed by staff through working parties and surveys. We saw a clear focus on putting people first and several staff we spoke with talked about being a family.
- All staff knew who the most senior managers within the hospital were. Staff told us these managers were very

visible on the wards, approachable and responsive to questions both in person and via email. The hospital director reported feeling supported by the senior leadership team.

Good governance

- The provider ensured there were effective systems in place to monitor key performance indicators for patient care and staff development, including; staff training; supervision and appraisals; staffing; incidents and complaints. The provider used computer systems that gave a summary of the risks, needs and staff performance for each ward (known as dashboards). A separate dashboard programme called Pathnav allowed staff to quickly look at a summary of key information for each patient, including; patient risk assessments; the status of each patient under the Mental Health Act; observation levels for each patient; activity hours; leave hours and several other key indicators. Dashboards allowed staff to monitor compliance with these indicators and the hospital director received regular updates from ward managers and training managers to keep up to date with omissions or trends. Managers at the daily morning meeting reviewed the dashboard for each ward. The provider also sent regular reports benchmarking the hospital's performance against other sites within the provider to the hospital director.
- The hospital director had introduced systems to improve the governance within the hospital and these changes had been well implemented. For example, the hospital director introduced a new observation and engagement policy and successfully trained all staff in the new process. They had continuously monitored and audited the use of this policy to make sure all staff knew how to apply this. In addition, each ward now had a charge nurse and a ward manager to ensure effective running of the wards and to provide the appropriate support to both patients and staff.
- The hospital director had introduced a hospital development plan. This outlined the areas in which the hospital aimed to improve and the steps being taken to achieve these improvements.
- The provider ensured staff received mandatory training and were regularly appraised and supervised. Staff reported incidents and followed safeguarding, Mental Health Act and Mental Capacity Act procedures. Staff had access to regular team meetings and information was shared across the hospital to support staff in learning lessons from incidents.
- A sufficient number of staff of the right grades and experience covered shifts. Staff maximised their shift-time on providing support and care to patients, rather than to administrative tasks.
- Staff had sufficient authority to complete their roles and were given the appropriate level of administrative support.
- The hospital maintained a risk register. Staff regularly reviewed this and updates were timely. The hospital ensured appropriate mitigating actions were put in place to reduce the risk of such events occurring.
- The provider did not have oversight of its use of blanket restrictions around patients' access to restricted items. Patients and staff we spoke with were not clear on how these restrictions were agreed upon, nor their therapeutic purpose.

Leadership, morale and staff engagement

- In order to encourage staff engagement and feedback, the provider had launched a 'Your Say Forum' and had undertaken the staff survey and employee engagement survey. The service was in the process of setting up listening groups and aimed to formulate an action plan from both the surveys and the listening groups.
- Staff reported that the senior leadership team, particularly the hospital director, communicated change well across the hospital and wider organisation.
- Staff knew how to use the whistleblowing process. Staff reported they were willing to use this process and were able to raise concerns without fear of victimisation. Staff felt able to discuss concerns with their managers and reported that change and feedback was communicated well.
- Staff reported that staff morale had increased since our last inspection. They said this was due to the support provided by the senior management team and they now had clear guidance and structure in day to day tasks, as well as an optimistic attitude to improvement. Staff felt supported by their colleagues and the wider team. We saw several examples of how staff were supported by the senior management team to continue in their roles whilst attending to personal circumstances.
- The provider gave staff opportunities for leadership development. All ward managers had completed or

were booked on to leadership training. A recently appointed ward manager had completed a one-day course called 'Moving into Management' as well as specific ward management training. One ward manager told us they were being supported to complete a diploma in management. The provider also supported administrative and secretarial staff to complete leadership and management training. One staff member had received approval from the provider to fund a training course, but this was later retracted and therefore the staff member had not been able to complete the course.

- Staff were also supported to complete training that encouraged their professional development. For example, the clinical services director was completing a masters degree in personality disorder, the consultant psychiatrist was supported financially to attend professional conferences and the social worker attended training around new welfare benefits.
- Staff reported they were given opportunities to give feedback on services and input into service development through clinical governance meetings, supervision and reflective practice.
- The hospital director had received training in interviewing to avoid bias in compliance with workforce race equality standard.

Commitment to quality improvement and innovation

- The hospital took part in national quality improvement programmes and was a member of the Quality Network for Forensic Mental Health services accreditation scheme. The hospital participated in the Quality Network Peer Review in April 2017.
- The hospital received three quality assurance marks from the Welsh Quality Assurance Inspection Team.
- The hospital was part of the RAID (reinforce appropriate, implode disruptive) Centre of Excellence for the Nottinghamshire region. The RAID approach is the United Kingdom's leading positive behaviour support approach to tackling behaviour that challenges. We saw this approach was well embedded within the service. Staff received training on its principle and application. The hospital reported this had resulted in a positive culture change, which focuses on the strengths and positive attributes of both patients and staff and therefore enhanced patient/staff interaction.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital's events planning team were nominated at the National Service Awards.
- The hospital were nominated for the provider's Pride award for "being a family and striving for excellence".

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure patients' observations are in line with the needs identified in their risk assessment.
- The provider should ensure lessons learned from incidents are shared across the whole hospital and changes are put in place as a result of these incidents.
- The provider should ensure patients are involved in the development of their discharge plans.
- The provider should ensure all staff are clear on the safe use of rooms where alarms are in use.
- The provider should ensure all staff are aware of the procedure for searching patients upon return from leave.
- The provider should provide clarity around the use of the words high-risk items, contraband and restricted items.
- The hospital should consider reviewing the food menu to provide more than one vegetarian option.