CareQuality Commission

Affinity Healthcare Limited

Cheadle Royal Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The environmental issues identified in our previous inspection in June 2021 had been addressed. All wards had been comprehensively redecorated and refurbished. Every ward had new furniture, fittings, and flooring had been fitted throughout. Improvements had been made to the maintenance systems and processes throughout the service.
- Ward teams had access to multidisciplinary staff and specialists. The eating disorder service had a dietician and two assistant dieticians. Staff could access additional training to develop their skills. The model of care on Fern ward (a female personality disorder ward) was a dialectical behaviour therapy model. All staff were trained in the approach, and staff could progress to undertake training to deliver group-based therapy sessions. The ward was decorated with prompts for patients and staff. Staff could follow up therapy-based sessions and practise techniques with patients between therapy. Nursing and support staff could describe the model and theory well and the approach was understood and embedded with staff and patients who we spoke to. The provider had a rolling programme of clinical audits for benchmarking and quality assurance.
- Patients said most staff were discreet, respectful, and responsive when caring for patients. Most patients told us that they felt that staff respected their privacy. The hospital had recruited two experts by experience who were due to start work imminently. Patients could give feedback on the service and their treatment and staff supported them to do this.
- Leaders were visible in the service and approachable for patients and staff. The ward managers were experienced and skilled and performed their role well. Staff told us they were visible, approachable, listened and supported them in their day to day tasks.

However:

- On two CAMHS wards we found doors that had been graffitied by patients who had chipped away the paint and this damage had not been addressed. It was not clear that any measures were in place or had been considered to prevent this from happening in the future. A damp patch on the ceiling of the laundry room on Orchard ward had not been addressed since the last inspection.
- The service had not ensured that clinic rooms within CAMHS were checked and maintained appropriately. On Orchard and Woodlands, there were areas of the clinic rooms that were dusty, cluttered and unorganised. Expired equipment such as gloves, needles and syringes were stored on all three wards and had not been removed. These were stored alongside in date items so it was not clear to staff which equipment they should use. On Orchard, there was medication that had been opened with no start or expiry date recorded. The hospital's governance processes had not ensured that the issues regarding the clinic rooms and medications were addressed in a timely and appropriate manner.
- On three of the wards (Pankhurst, Alder and Featherstone) patients told us of concerns about a negative culture that had developed in relation to night. Patients said they did not always feel safe on these wards, they found staff were less supportive and less respectful. Patients on two wards told us there had been mistakes made at night with their medication which they had had to report. These issues were similar to those we found on one ward at our last inspection which the provider had addressed.
- Whilst overall governance had improved, there were issues with oversight of some areas of practice, including ward-based audits and checks and physical health assessment and monitoring.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good ●	Our rating of this core service has improved. We rated it as good because:

- The wards we visited were comfortable and calm environments. The environmental issues identified in our previous inspection in June 2021 had been addressed. All wards had been comprehensively redecorated and refurbished. Wards were decorated in neutral colours which was particularly beneficial in the lower floor wards where this enhanced the natural light available. Every ward had new furniture and fittings, and new carpeting had been fitted throughout. Improvements had been made to the maintenance systems and processes throughout the service.
- Ward teams had access to multidisciplinary staff and specialists and there was good psychology provision. Staff could access additional training to develop their skills including training all staff in understanding autism. The provider had a rolling programme of clinical audits for benchmarking and quality assurance.
- Patients said most staff were discreet, respectful, and responsive when caring for patients. Most patients told us that they felt that staff respected their privacy. The hospital had recruited two experts by experience who were due to start work imminently. Patients could give feedback on the service and their treatment and staff supported them to do this.
- 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 or access hot drinks and snacks at any time.
- Leaders were visible in the service and approachable for patients and staff. The ward

Summary of findings

managers were experienced and skilled and performed their role well. Staff told us they were visible, approachable, listened and supported them in their day to day tasks.

However:

- Whilst overall governance had improved, there were issues with oversight of some areas of practice, including ward based audits and checks and physical health assessment and monitoring.
- On three of the wards (Pankhurst, Alder and Featherstone) patients told us of concerns about a negative culture that had developed in relation to night. Patients said they did not always feel safe on these wards, they found staff were less supportive and less respectful. Patients on two wards told us there had been mistakes made at night with their medication which they had had to report. These issues were similar to those we found on one ward at our last inspection which the provider had addressed.

Child and adolescent mental health wards	Requires Improvement ●	Our rating of this core service stayed the same. We rated it as requires improvement because:

- The provider had undertaken a programme of maintenance since the last inspection in July 2021. However, we found that although the doors had been painted as part of the maintenance programme further damage had been done and doors were now chipped and damaged again. More robust methods of ensuring continuous reparation of damage, such as replacing the doors, had not been considered. It was not clear that any measures were in place or had been considered to prevent this from happening in the future. A damp patch on the ceiling of the laundry room on Orchard ward had not been addressed since the last inspection.
- The service had not ensured that clinic rooms were checked and maintained appropriately. On Orchard and Woodlands, there were areas of the clinic rooms that were dusty, cluttered and unorganised. Expired equipment such as gloves,

Summary of findings

needles and syringes were stored on all three wards and had not been removed. These were stored alongside in date items so it was not clear to staff which equipment they should use. On Orchard, there was medication that had been opened with no start or expiry date recorded.

- The hospital's governance processes had not ensured that the issues regarding the clinic rooms and medications were addressed in a timely and appropriate manner.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of the children and young people. They actively involved children, young people, families and carers in care decisions.

Specialist eating disorder services

Good ●

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The service clinic rooms were safe with all equipment regularly serviced.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. All patients had been assessed by a dietician within 24 hours. Staff engaged in clinical audit to evaluate the quality of care they provided.

Summary of findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. New staff had been employed to work in the dining areas only to offer more support to patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Patients thought staff cared about them.
- Leaders were visible in the service and approachable for patients and staff. The ward managers were experienced and skilled and performed their role well. Staff told us they were visible, approachable, listened and supported them in their day to day tasks.

However;

- Patients told us that issues connecting to the internet were still unresolved from our previous inspection.

Summary of findings

Contents

Summary of this inspection

Background to Cheadle Royal Hospital

Cheadle Royal Hospital which is part of Affinity Healthcare Limited (operating as the Priory Group) was in Cheshire and had been registered with the Care Quality Commission since December 2010.

The hospital was registered with the CQC to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury

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

There are seven acute and PICU wards:

- Alder
- Pankhurst
- Featherstone
- Fern
- Maple
- Willows
- Mersey Lodge

This core service was last inspected in June 2021 where we rated safe as inadequate, caring and well led as requires improvement and effective and responsive as good.

Child and adolescent mental health wards

There are three child and adolescent mental health wards:

- Woodlands
- Orchard
- Meadows

This core service was last inspected in June 2021 where we rated safe as inadequate, caring and well led as requires improvement and effective and responsive as good.

Specialist eating disorder services

There are two specialist eating disorder wards:

- Cedars
- Aspen

Due to the concerns we found during our inspection in all three services in June 2021, we asked the provider to take urgent and immediate action.

Summary of this inspection

The provider addressed the most serious concerns immediately.

We also issued warning notices for two breaches of regulation to ensure that swift action was taken, and plans put in place to maintain improvements.

We told the provider it must maintain medical equipment.

We told the provider it must improve the environment in the Acute wards for adults of working age and psychiatric intensive care units and Child and adolescent mental health wards.

What people who use the service say

We spoke with 46 patients,

All patients we spoke to said that there were staff on their ward who were caring and supportive. One patient told us the ward was "the best place, staff are caring and compassionate, they really go the extra mile" with another describing staff as "brilliant". Patients described nursing staff as "lovely, caring, easy to talk to, non-judgemental, approachable and friendly."

However, nine patients on four different acute service wards referred to a different culture at night, "the ward changes at night with different staff team". Four patients said they did not feel safe at night on their wards. Patients spoke of staff being less supportive, less respectful, speaking in other languages between themselves in communal areas, spending time on their phones and being dismissive and unapproachable. On one ward, a patient told us they had been referred to by their bedroom number rather than their name; another patient on the ward told us they had been there for six months and didn't know regular night staff members' names. Patients on two wards told us there had been mistakes made at night with their medication which they had had to report.

On CAMHS two children and young people felt that there could be more activities on the ward. One young person felt that staff were not always responsive and were not always respectful.

All patients complained about poor wireless broadband and their ability to get online.

How we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

The team that inspected the three core services comprised four CQC inspectors and four special professional advisors.

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:

- visited nine wards at the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 46 patients who were using the service;
- spoke with two carers/family members of patients who were using the service;

Summary of this inspection

- spoke with nine ward managers;
- spoke with 42 staff members including nurses, health care assistants, consultant psychiatrist, clinical psychologist, dietician, assistant psychologist, physical health specialist and cleaners;
- looked at 53 care and treatment records of patients and 51 prescription charts and
- 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.

Outstanding practice

We found the following outstanding practice:

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

- We found Fern ward to be an innovative service. There was a truly holistic approach to assessing, planning and delivering care and treatment.
- The model of care on Fern ward was a dialectical behaviour therapy model. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. All ward based and multidisciplinary staff who worked on the ward were trained in the approach, including support workers. This meant that staff could follow up therapy-based sessions and practise techniques with patients between therapy and the ward routines and ethos were underpinned by the therapy model. Nursing and support staff could describe the model and theory well and the approach was understood and embedded with staff and patients who we spoke to.
- A proactive approach to anticipating and managing risks to patients was embedded and was recognised as being the responsibility of all staff. Patients and those close to them are actively involved in managing their own risks.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was effective, kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring and supportive.

Child and adolescent mental health wards

- On Woodlands, the female low secure ward, the Occupational Therapist had implemented vocational roles for the young people such as a barista, librarian and working in shake shack. The roles had been designed with a clear process that replicated applying for jobs and set out expectations for the young people engaging in the roles. These roles encouraged engagement and interactions for the young people, along with teaching them about the responsibilities and expectations of having a job.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a 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 MUST take to improve:

Summary of this inspection

- The service must address long standing issues of poor network coverage and poor internet connectivity which affects patients maintaining relationships with family and friends (Regulation 17 Good Governance)

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

- The service must ensure that there is central oversight of processes for checking equipment and ward-based audits to ensure these are completed correctly. (Regulation 17 Good Governance)
- The service must ensure senior management oversight of physical health care including processes for physical health assessment and monitoring and Venous Thromboembolism (VTE) risk assessments (Regulation 17 Good Governance)
- The service must ensure they follow guidance relating to pregnancy prevention plans for women of childbearing age prescribed sodium valproate (Regulation 17 Good Governance)
- The service must address concerns raised about night staffing and negative cultures (Regulation 17 Good Governance)

Core/additional service [Child and adolescent mental health wards]

- The provider must ensure that improvements are made to the environment and must ensure that actions are taken to prevent any future deterioration of the environment (Regulation 15(1)(2)).
- The provider must ensure that medications and equipment are stored, checked and maintained appropriately (Regulation 12(2)(e)(f)(g))
- The service must ensure that governance processes are in place to effectively monitor operations across all areas (Regulation 17(1)(2)).

Action the service SHOULD take to improve:

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

- The service should ensure that they continue to address shortfalls in staff training, particularly immediate life support and reducing restrictive intervention training.
- The service should ensure oversight of maintenance issues and timescales.
- The service should ensure that patients have individualised, documented strategies for reducing risk of violence and aggression when medicines are prescribed to be given when required or for rapid tranquillisation.

Additional service [Child and adolescent mental health wards]

- The service should ensure that any verbal apologies made in relation to incidents identified as meeting the threshold for duty of candour are followed up by a written apology.
- The service should continue to monitor and ensure that mandatory training compliance rates improve.
- The service should ensure that any new process or protocol implemented on the wards is clearly documented. The service should consider how it evaluates any new process or policy to understand and evidence how effective it is.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Requires Improvement	Good
Child and adolescent mental health wards	Requires Improvement	Not inspected	Good	Not inspected	Requires Improvement	Requires Improvement
Specialist eating disorder services	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

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

Good ●

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

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

Good ●

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

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

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

At the previous inspection in 2021, we noted that furniture blocked corridors and fire exits. There were no issues at this inspection, on all wards visited corridors and fire exits were clear of obstruction.

Staff could observe patients in all parts of the wards.

All wards had blind spots where observation was more difficult, often because of building features such as corners and recesses. These were captured as part of the six-monthly ligature risk audit and mitigated where possible. Closed circuit television was in place on all wards we visited, which covered communal areas and corridors, but not bedrooms or bathrooms.

The wards complied with guidance relating to mixed sex accommodation.

Alder and Maple wards were both mixed sex wards. Male and female bedrooms were located on separate corridors. There were no breaches of this (for example, a male patient placed in a bedroom on a female corridor). Both wards had a designated female lounge.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Comprehensive ligature risk assessments were undertaken every six months. We saw that these were re-visited and updated following changes to the wards, for example, when new furniture was installed.

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

Good ⬤

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

All staff on the wards we visited had sufficient alarms available. We saw that these were re-ordered as needed.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

All wards had been comprehensively redecorated and refurbished since the previous inspection. Wards were decorated in neutral colours which was particularly beneficial in the lower floor wards where this enhanced the natural light available.

Every ward had new furniture and fittings, and new carpeting had been fitted throughout.

On Featherstone ward we noted the new carpeting was becoming worn on the main corridor and in the ward office the vinyl flooring had bubbled and split, these seemed to be caused by the underlying structure. On Alder ward, an upstairs bathroom used by staff showed evidence of water damage. On Willows ward, the carpeting was stained in one of the meeting rooms, and there was perished sealant around a shower base. On Maple ward, there was an overwhelming smell of damp in the visitor's room on the ward, ward staff said issues with the damp had not been able to be resolved.

For the most part, staff said that maintenance reporting and actions were much improved. The provider recognised that there needed to be a review of the oversight of maintenance, including where issues were not reported or not resolved in a timely fashion.

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

Staff followed infection control policy, including handwashing.

At the time of this inspection, the provider had protocols in place to manage healthcare transmission of Covid19 and staff followed these.

Seclusion room (if present)

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

The psychiatric intensive care wards had seclusion facilities. These were all visited as part of this inspection and we found no concerns with them. None were in use at this inspection.

Clinic room and equipment

Staff checked, maintained, and cleaned equipment.

Staff completed checks on medical emergency equipment and staff were monitoring the equipment on all wards for the integrity of the security seal. However, not all the wards were monitoring the equipment's expiry dates themselves. Several items were found to have recently expired, suggesting the central process required reviewing. However, essential equipment was clean, in-date and regularly serviced.

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.

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

Good 🟢

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service had vacancies for nursing staff across the wards we visited. The service used bank and agency nurses to cover when needed for vacancies, staff sickness and increased observation levels. Managers mostly limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The hospital had increasing turnover rates over the last 12 months, data was gathered by staff groups rather than by service. Turnover was highest for administration staff and at support worker level.

Managers supported staff who needed time off for ill health. Levels of sickness were low and / or reducing. The average sickness rate across the hospital in the last 12 months was between 5%-6% with the exception of early 2022 owing to a national surge in Covid19 cases and staff isolating.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward managers could adjust staffing levels according to the needs of the patients. Managers had flexibility to adjust staffing to meet patient needs, including when organising periods of leave and to ensure staff cover for activities. Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. 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.

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. Doctors had arrangements for cross cover of each other's wards for leave. In the evenings and at weekends, a duty doctor covered the whole site with consultant on call cover also rostered.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All mandatory training had been completed by the majority of staff, with the exception of immediate life support training for registered nurses and reducing restrictive intervention training.

Immediate life support training had been completed by 78% of registered nurses, with lower levels of 57% and 67% of staff on Featherstone and Fern respectively. Reducing restrictive intervention training had been completed by 74% of staff across the service, with the lowest levels on Alder ward (65%), Featherstone ward (69%), Fern ward (69%) and Maple ward (77%). All staff completion of basic life support training was 96% across the wards.

The provider told us that these two training programmes had been affected by the Covid19 pandemic and a reduction in face to face training. Whilst there had been courses routinely offered since the start of the year, attendance had been affected by staff being off work due to high numbers of community Covid19 infections and staff otherwise needing to isolate.

In mitigation, the provider told us they reviewed at each morning meeting with all the ward managers staff deployment across site and ensuring adequate training. This included the identification of staff allocated to be responders to all psychiatric and physical health emergencies throughout the hospital. Only trained and updated staff were allocated to the response team.

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

Good ●

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. There was an onsite learning facilitator who booked courses and allocated staff to places and they were in the process of prioritising staff to attend training and rebooking staff who had missed attending due to illness. Staff told us they were booked onto training in the near future.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

We reviewed 28 patient records. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a recognised risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to, or posed by, patients. We saw levels of observation that changed to reflect the current needs of each patient. Staff communicated each patient's level of risk well, via a number of different methods, for example on a computerised system, on a chart in the staff offices and displayed on the observation files. The observation files also contained a brief risk profile for each patient that was easily accessible for all staff. Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Searching was only completed on an individual risk basis.

Use of restrictive interventions

Levels of restrictive interventions were reducing. In the last 12 months, there had been 787 episodes of restraint across the seven wards. Rates were highest on Fern and Pankhurst wards. This was lower than previous data received for the 12 months from 2020 – 2021 which we reviewed at the last inspection, although it is difficult to benchmark data due to changes in client group. There had been four episodes which included brief prone restraint, which were for less than a minute on each occasion.

In the last 12 months, there had been 216 episodes of seclusion. Seclusion use was highest on Featherstone ward, which accounted for 113 episodes. Figures were lower than those from the last inspection with a notable reduction of seclusion episodes on Pankhurst ward, with figures a third of what they had been previously. In the last 12 months, there had been 12 episodes of long-term segregation.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Managers completed audits of their wards to check restrictions in place, including blanket restrictions and any inadvertent restrictions on patients' visiting, meaningful activity and cultural or religious needs. These showed for all wards visited that restrictions were implemented on an individual basis and for clinical reason.

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.

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

Good ●

We reviewed clinical records and incident data for these wards and saw restrictive interventions used only as a last resort.

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

Staff mostly followed NICE guidance when using rapid tranquilisation. However, we found a lack of records of post rapid tranquilisation physical health monitoring on two wards. There was some variation on where the records were being held and how long they were retained for in a person's individual files. This was not consistent across the hospital and staff struggled to find the records on some occasions. The service monitored the use of rapid tranquillisation and any key themes or trends. In the last 12 months the highest use had been on Pankhurst and Fern wards.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was in long-term segregation.

At the time of this inspection, there were no patients in seclusion. One patient was cared for in a bespoke, individual placement and this was recognised as long-term segregation. Staff followed the Mental Health Act Code of Practice, including arranging external care reviews.

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 attended safeguarding adults and safeguarding children training. Staff kept up-to-date with their safeguarding training. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff outlined the steps they would take to report safeguarding concerns.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe. A visiting room for children visiting was available to book in the main hospital building away from the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a corporate Safeguarding Children and Adults policy. A safeguarding team was based within the hospital to provide support and advice for staff and to oversee any ongoing safeguarding plans or processes.

Managers took part in serious case reviews and made changes based on the outcomes.

Managers and staff had been involved in investigations into serious incidents which occurred. We saw recent investigations where initial findings and concerns were actioned immediately.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. The service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

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

Good ●

The provider used an electronic patient records system. Key service information, including policies and procedures, was also available electronically.

Printed copies of some electronic records, for example, personal emergency evacuation plans, were stored on the ward and accessible in the event of fire. We also saw that where staff did not have access to the electronic records system, summaries and paper copies of key information were available on the wards.

However, physical health monitoring was completed on paper forms using the National Early Warning Score (NEWS2) system, using online versions of these forms, and in the clinical notes, so there was not one complete set of observations which made it difficult for staff to have a complete overview of a patient's physical health.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. However, they did not always use systems and processes to safely prescribe and administer medicines.

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

However one person who was prescribed sodium valproate, who was of child-bearing age, did not have the pregnancy prevention programme in place. The medicine should not have been prescribed without this in place.

Staff completed medicines records accurately and kept them up to date. Medicine administration was recorded on a person's prescription chart and was part of ward daily checks. There was an external pharmacy provider that attended to hospital weekly to review prescription charts and provide feedback to staff.

Staff stored and managed all medicines and prescribing documents safely. However, we found that the waste medicine disposal bin on one ward contained additional items to the "tablets only" marked on the container. These included expired insulin pens, a pump spray and inhalers. The bin itself was easily opened and removal of the medicines was possible.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The person's previously prescribed medicines and relevant allergy information was available for most people, on those records examined.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. However, there was no differentiation on the prescription charts and within their care plans for three people who were prescribed more than one medicine for severe aggression/agitation. This meant staff did not have an individualised, documented strategy for reducing risk of violence and aggression using medicines prescribed to be given 'when required'. This meant there was a risk of people being given an inappropriate medicine or dosage leading to a possible increased risk of side effects or escalation of behavioural issues.

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

Good ●

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. However, we found a lack of records of monitoring on two wards, including blood results for specific medicines. There was some variation on where the records were being held.

Track record on safety
The service had a good track record on safety.

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

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Incident forms were well completed by staff and reviewed by managers.

Staff reported serious incidents clearly and in line with policy.

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

Managers debriefed and supported staff after any serious incident. Nursing staff on the wards also completed debriefs following incidents, involving staff and patients affected appropriately.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw that these were discussed in team meetings.

Staff met to discuss the feedback and look at improvements to patient care. The provider quality leads had compiled a safety bulletin with information for staff following incident investigations.

There was evidence that changes had been made as a result of feedback. Following a serious incident earlier in the year, immediate changes had been made to the ward involved to reduce the risk of a similar incident occurring.

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

Good ●

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

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

Good ●

Assessment of needs and planning of care

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

We reviewed 28 patient care records.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients did not always have their physical health assessed soon after admission and regularly reviewed during their time on the ward. When patients refused to engage with physical assessment at admission, it was not evident in records whether this was revisited or reattempted. Whilst there was evidence of physical health monitoring in some patient records, routine monitoring was not evident for all patients. Physical assessments at admission were mostly recorded in the medical notes, and the provider physical health assessment tools were blank. Nursing staff completed physical health monitoring in different places on different wards, and often there were NEWS2 recording forms in paper and electronic format, along with monitoring noted in clinical notes. This raises the risk of changes in a patient's physical health being missed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service.

All acute and PICU ward patients could access psychology support. Psychology staff also supported staff on wards with formulations and reflective practice support for ward based staff.

The model of care on Fern ward was a dialectical behaviour therapy model. All ward based and multidisciplinary staff who worked on the ward were trained in the approach, and staff could progress to undertake training to deliver group-based therapy sessions. The ward was decorated with prompts from the training for patients and staff and being trained in the approach meant staff could follow up therapy-based sessions and practise techniques with patients between therapy. Nursing and support staff could describe the model and theory well and the approach was understood and embedded with staff and patients who we spoke to.

Staff delivered care in line with best practice and national guidance. (from relevant bodies eg NICE)

Care on acute and PICU wards was in line with NICE guidance including prevention and management of psychosis and schizophrenia guidance (CG178) and guidance on violence and aggression: short-term management in mental health, health and community settings (NG10).

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

Good ●

Psychiatric intensive care wards followed guidance and were working towards accreditation with the national association of psychiatric intensive care and low secure units.

Staff identified patients' physical health needs and recorded them in their care plans. We found that the staff were not completing Venous Thromboembolism (VTE) risk assessments for people on admission to the hospital as recommended by the NICE guidance NG89 (2018) and the provider's policy document. On one ward, a patient had been admitted who was already at an increased risk due to previous history of deep vein thrombosis (DVT) and pulmonary embolism (PE). They did not have an admission VTE risk assessment or ongoing care plan in place.

Staff made sure patients had access to physical health care, including specialists as required.

However physical health monitoring was being completed in different places, including paper records and the electronic record system, and routine physical observations were not always being completed by nursing staff.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Most wards had exercise machines or small gyms, and outdoor space for exercise. The service was planning to become a smoke free site in the near future and was engaged in sessions about smoking cessation and alternatives.

On Pankhurst and Fern wards, there was information promoting primary care physical health checks, including breast cancer checks and cervical screening information.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included the use of the model of human occupation screening tool by occupational therapy staff and recognised side effects rating scales by nursing and medical staff.

Staff used technology to support patients. The service had used virtual calls during the recent pandemic to ensure that family members and care team staff could attend multidisciplinary meetings. The site had wi-fi for patients to use, but the quality of this overall was variable depending on the location of the wards and the provider had been looking at how this could be improved for some time. Some short-term fixes had been attempted but issues were still reported with connectivity.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

The service undertook a rolling annual programme of clinical audits, which allowed for benchmarking and comparison. These included safeguarding, Mental Health Act, infection prevention, seclusion, observation, reducing restrictive interventions and care documentation.

Ward managers completed monitoring forms for any use of rapid tranquillisation or seclusion within their services. These were reviewed at regular clinical governance and reducing restrictive interventions meetings.

The pharmacy provider completed weekly audits which focused on prescription writing, medicines administration and an audit of the clinic room. These were reviewed and actioned by ward managers and reviewed at service level in a monthly medicines management meeting.

Across the services, there was evidence of a renewed focus on some of the safewards initiatives and reintroducing these.

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

Good 🟢

On Pankhurst ward, there had been a series of initiatives to support night staff, including community meetings held during the night and reflective practice sessions run at night.

Managers used results from audits to make improvements. For example, ward managers went through care record audits with nursing staff in supervision and as part of team meetings, highlighting good practice and areas for improvement.

The service managers completed quality walk arounds on each ward area, with actions plans and improvements needed developed from these.

Skilled staff to deliver care
The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). 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.

All wards had medical cover, psychology and occupational therapy provision. Some wards were sharing the time of one occupational therapist and had recruited technical instructors and funded additional staff shifts to provide ward based activities. The hospital was actively recruiting for additional occupational therapists and assistants.

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.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us their induction programme had been comprehensive and prepared them for their roles.

Managers supported staff through regular, constructive appraisals of their work. An appraisal cycle took place each year.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. At the time of this inspection, 86% of staff had a completed appraisal.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. At the time of this inspection, 83% of medical staff had a completed appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Medical staff received regular, constructive clinical supervision of their work.

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

Team meetings generally took place on a monthly basis on wards. These were minuted and the minutes were sent to teams by email and displayed in staff areas.

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

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

Good ●

Staff told us this formed part of their appraisal process and additional training was available. Support workers told us they had been able to apply for nurse associate training which offered an opportunity for promotion.

Managers made sure staff received any specialist training for their role. The service was now training all staff in understanding autism, with an average of 94% of staff across the seven ward areas trained. All staff working in Mersey Lodge had completed this training.

Staff on Fern ward received in-house dialectical behaviour therapy training, with regular places offered on intensive dialectical behaviour therapy external training. Staff also attended in-house specialist training including mindfulness, distress tolerance, interpersonal effectiveness and boundaries. Some staff had completed mental health first aider training to enable them to provide peer support to colleagues.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

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

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

These were held on a weekly or fortnightly basis on wards. The hospital management team and senior clinicians also met each week to discuss ward issues, additional staffing needs and any clinical or ward related issues.

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

Most staff worked a long day shift system so staff handed over at the start of the day shift and the start of the night.

Ward teams had effective working relationships with other teams in the organisation.

All the wards we visited worked closely with the other wards on site.

Ward teams had effective working relationships with external teams and organisations.

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.

A Mental Health Act reviewer joined the inspection team on-site for a day to review the administration of the Act. They spent time with the Mental Health Act administrators on site. They reviewed six patients' files and documentation and reviewed checklists used for scrutiny of documents (admin and medical), renewal process, tribunal appeals and hospital managers' hearings. They also reviewed information sent to patients and their nearest relatives including information regarding rights and access to advocacy services.

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

Good 🟢

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. Across all seven ward areas, 94% of staff had completed Mental Health Act training.

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.

The hospital had recently recruited to a team of Mental Health Act administrators. The new team had been supported since starting and had reviewed and devised systems and ways of working to ensure they had good oversight of the Mental Health Act across the service.

Staff fed-back that the team were proactive when reports or information was needed and ensured the provider policies and the Mental Health Act code of practice were followed.

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

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

Information about the advocacy service was displayed on wards and staff and patients know how to contact them.

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

Staff 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.

Staff did not always request an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

On two wards, copies of consent forms (T2) included injectable medicines for use in an emergency (rapid tranquillisation) and section 62 authorisations for emergency or short term treatment were being used to authorise ongoing treatment without a request being made for a Second Opinion Appointed Doctor (SOAD) opinion.

On one ward, we saw treatment prescribed which had not been authorised by a Second Opinion Appointed Doctor (SOAD), this had not been given and was crossed off the chart when raised with medical staff.

On one ward, consent forms (T2) included high dose antipsychotic treatment approval, specific classes of medication and intramuscular medication authorisations, despite these not being prescribed.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Copies of detention papers and records were maintained on the electronic record system.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

Good 🟢

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

The Mental Health Act administrators undertook periodic audits to ensure paper and electronic files matched and that ward based information was up to date. There were also ward based audits completed by managers checking patients were being informed of their rights under the act and that leave arrangements were recorded correctly.

The administration team had identified areas they would like to improve and had plans to make changes and improvements.

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.

At this inspection, the average number of staff up to date with training in the Mental Capacity Act was 90% and the deprivation of liberty safeguards was 89%.

There were no deprivations of liberty safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff told us they would contact the Mental Health team, managers and/or the safeguarding team, depending on the situation.

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

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

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

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

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

Good 🟢

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

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

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. The environment now reflected a caring environment which aided recovery. However, a number of patients raised concerns about a more negative culture at nights on some of the wards.

We spoke to 22 patients across the wards.

All patients we spoke to said that there were staff on their ward who were caring and supportive. One patient told us the ward was "the best place, staff are caring and compassionate, they really go the extra mile" with another describing staff as "brilliant". Patients described nursing staff as "lovely, caring, easy to talk to, non-judgemental, approachable and friendly."

However, nine patients on three different wards referred to a different culture at night, "the ward changes at night with different staff team". Four patients said they did not feel safe at night on their wards. Patients spoke of staff being less supportive, less respectful, speaking in other languages between themselves in communal areas, spending time on their phones and being dismissive and unapproachable. On one ward, a patient told us they had been referred to by their bedroom number rather than their name; another patient on the ward told us they had been there for six months and didn't know regular night staff members' names. Patients on two wards told us there had been mistakes made at night with their medication which they had had to report.

A previous Mental Health Act reviewer visit had resulted in similar feedback for one ward, and an action plan was in progress for this ward, including additional support and supervision at nights and some shift rotation. We fed back the concerns above relating to night shifts during inspection, and the provider took immediate actions to start to address these concerns.

Patients said most staff were discreet, respectful, and responsive when caring for patients. Most patients felt that staff were respectful and respected their privacy. Two patients told us staff would enter their rooms at times without knocking or announcing, but most patients said staff knocked or called before entering.

Staff gave patients help, emotional support and advice when they needed it. Patients gave personal and individualised feedback about support they'd received during difficult times.

Staff supported patients to understand and manage their own care treatment or condition.

There was positive feedback from patients about psychology provision across all the wards we visited, and the benefits patients had had from this. Fern ward operated on a dialectical behavioural therapy model, with all staff being trained in the approach to help patients manage emotional dysregulation and times of feeling out of control and in crisis. We spoke to patients who felt the therapy was going well and that they were making progress on the ward. Staff were described as caring, lovely, supportive and consistent.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient.

Staff followed policy to keep patient information confidential. None of the patients we spoke to raised issues about confidentiality concerns.

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

Good ●

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Most patients were aware of the contents of their care plans and had been involved in devising these. In 18 of the 28 care records we reviewed there was indication of care plans being offered to patients, however none of the patients we spoke to said they had a copy of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff worked in individual ways with patients to help them understand their care and treatment, including when some patients were admitted and were acutely unwell. In one patients' care, there was good use of social stories to prepare for changes and progress with their care plans.

Staff involved patients in decisions about the service, when appropriate.

The hospital had recruited two experts by experience who were due to start work imminently.

Patients could give feedback on the service and their treatment and staff supported them to do this. All wards had regular community meetings where patients could feedback on the service. Each ward had a "you said, we did" board which could be used to highlight what was raised and what had been done. Some of these were regularly updated and included changes suggested by patients, for example, a sensory room was being developed on Pankhurst ward after suggestions by patients.

The service completed satisfaction surveys with patients at the point of discharge, which were reviewed by managers each month along with any actions needed. The response rate to these was low, with few responses received, so it was difficult to draw meaningful conclusions. The hospital manager and ward managers had arranged for QR codes to be displayed around site to allow easier access to the online surveys via mobile devices.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Patients told us of their input and support from the advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke to two carers who gave positive feedback on the service.

Staff supported, informed and involved families or carers.

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

Good ●

Visiting was in place on all wards we visited. On Pankhurst ward there were information booklets for visitors on arriving at the ward. Fern ward had a noticeboard of information for visitors, and as some visitors may travel some distance there was a map and directory of local services, including accommodation, cafes and restaurants and local taxi companies.

Staff helped families to give feedback on the service.

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

Good ●

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

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

Bed management
Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service had local commissioning arrangements with nearby NHS trusts and also had patients admitted from out of local area.

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

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

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care
Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

In the last 12 months to March 2022, there were 73 patients who had experienced a delay to their discharge from the acute and PICU wards. Delays tended to be due to a need to wait for appropriate onward accommodation in the patient's home area, including step down hospital placements. Most patients were delayed by weeks but a small number of patients had waited months for transfer or discharge. Sixteen patients waited over 6 months to move on, with the most patients delayed from Pankhurst ward numbering eight patients.

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

Good ●

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. On some wards with commissioned beds, regular meetings were held with the commissioning organisation to ensure plans were in place for transition back to home areas. Staff supported patients when they were referred or transferred between services.

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 or access hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients were able to personalise rooms with their own belongings and pictures. Patients had a secure place to store personal possessions. Most wards had had new bedroom furniture fitted, which included lockable storage.

Staff used a full range of rooms and equipment to support treatment and care. All the wards we visited had a number of rooms on the ward which could be used for activities and therapy sessions. Some wards had adapted uses of rooms according to patient requests, finding space for gym equipment on a couple of wards and basketball practice on Willows ward. Sensory equipment had been ordered for Pankhurst ward to convert an unused room into a small sensory space. Fern ward was a more recent purpose-built ward and had activity and arts rooms, group and therapy rooms, a quiet lounge, de-escalation lounge and a small prayer room.

The service had quiet areas and a room where patients could meet with visitors in private. All wards had quiet rooms and designated rooms used for visitors. The visitor's room on Fern ward was off the main ward and was a large welcoming room with drinks facilities and comfy furniture. Patients could make phone calls in private. Most patients had mobile phones that they could use on the ward or in bedrooms. Patients could also use cordless phones available to use on the wards.

The service had outside spaces that patients could access easily. All wards had garden areas which patients could access.

Patients could make their own hot drinks and snacks and were not dependent on staff. On the psychiatric intensive care wards, kitchen access was assessed and if patients were assessed as too high risk to be able to access kitchens themselves staff would make drinks and snacks as needed. Cold drinks, snacks and fruit were available on all wards we visited.

The service offered a variety of good quality 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 were able to access local community facilities when out on leave.

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

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

Good ●

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.

The wards in the main hospital were accessible by lift, and adjustments could be made to allow access to the ground and lower floor wards for patients with mobility issues. Fern ward had been built with a fully accessible en-suite bedroom allowing wheelchair access and the whole unit was arranged on one level.

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

Information was displayed on all wards outlining the advocacy service, other local services including welfare rights and how to complain. Information on treatments and medicines could be printed for patients.

The service had information leaflets available in languages spoken by the patients and local community.

The wards could access services for leaflets and information in a range of languages other than English if needed.

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

There had been 18 complaints in the last 12 months relating to these wards. Three complaints were upheld and eight were partially upheld. There had been no complaints to the parliamentary and health service ombudsman.

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

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

Good ●

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was often shared via staff team meetings.

The service used compliments to learn, celebrate success and improve the quality of care.

The service collected compliments and ensured patients and staff were aware of them. On Fern ward, staff and patients could leave feedback and compliments for others in a jar, which were read through each week at the community meeting. Managers on some wards were able to offer rewards and tokens for staff for positive feedback, and some nominated an employee of the month each month. We saw positive feedback given to staff teams via newsletters and staff meetings.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement ●

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

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.

Leaders provided clinical leadership.

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

The ward managers were experienced and skilled and performed their role well. Staff told us they were visible, approachable, listened and supported them in their day to day tasks. They were willing to get involved in day to day work where needed, to support staff and patients to deal with difficult situations. Staff reported feeling valued by their manager and received regular feedback. Ward managers could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. The hospital director had returned their office to its original location next to the entrance hall directly opposite reception. This meant that all staff and visitors passed their office door when entering and exiting the hospital. Staff we spoke to all mentioned that they had an open-door policy and that they were extremely visible.

Vision and strategy
Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

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

Good ●

Staff know and understand the vision and values of the team and organisation.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

Senior hospital managers, ward managers and staff all referred to Cheadle Royal as somewhere they were proud to work. The phrase "Cheadle family" was often used. Ward managers promoted the behaviours that Priory aspires to. Putting people first, being supportive, acting with integrity, striving for excellence and being positive.

Culture

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

Staff felt respected, supported and valued. Staff were very positive about working for the service and felt part of the wider organisation. Staff felt positive and proud about working for the provider and their team. Leaders within the service spoke highly of their teams. The teams worked well together and there was a positive staff culture.

The provider recognised staff success within the service. This included through staff awards, but also at a ward-based level recognising individual staff members who had performed well.

The service responded proactively to bullying and harassment cases. All staff told us they felt the service had an open culture where they could raise concerns without fear. Those that had raised concerns felt listened to and that action had been taken. Staff were aware of the whistle-blowing process and where to find the policy.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff appraisals included conversations about career development and how it could be supported.

Staff were supported and encouraged to take on more senior roles. Hospital managers worked with staff to implement development plans. They told us they had succession plans in place to upskill staff to become leaders or more senior practitioners in the event of staff leaving. For example, staff were encouraged to complete leadership courses and we spoke to managers who had completed or were in the process of completing leadership training. Support staff were able to apply for nurse associate and assistant practitioner training funded by the company.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

The service had acted prior to this inspection about concerns raised about night staffing and a negative culture which had been alleged to have developed on one ward. At this inspection, patients on that ward and two other wards told us of similar concerns about night staffing. Whilst the provider had acted when initial concerns had been raised, they had failed to assess whether this affected more than just one ward within the service.

Governance

A new hospital manager had been appointed since the last inspection in July 2021. They had maintained the governance structure which had an overarching clinical governance committee chaired by either the hospital or medical

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

Good ●

director. There were another eight sub-committees that reported directly to the committee. They covered the core services and thematic issues such as safeguarding, infection control, risk and restrictive practice, medicine management, staff engagement, health and safety and quality. These sub-committees included members from ward-based staff.

We saw that there was a clear framework for team meetings with a set agenda which ensured that information, such as learning from incidents and complaints, was shared and discussed.

Whilst overall governance had improved, there were still issues which were identified at this inspection which affected most or all ward areas and had not been identified or appropriately managed.

At the last inspection, there had been major issues with maintenance and disrepair, which at this inspection were improved, with additional maintenance staff employed and new processes to follow for repairs and reports. However, we found there was no central oversight of maintenance issues and timescales. There were isolated examples of maintenance issues which had either not been reported or not been resolved.

At the last inspection, many clinical items, particularly resuscitation equipment, was out of date or required servicing. This was much improved, although there were still items of equipment on most wards which were out of date. Whilst a new process had been developed, this was not effective.

We found issues on all wards in relation to physical health initial assessment and monitoring. At a senior management level, managers outlined the process for completion of a physical health initial assessment at admission and routine monitoring after. This was not happening and each ward had their own systems and preferences for recording information. There was one physical health nurse for the entire site and little senior management oversight and support.

On some wards, we found issues with ward based audits, for example, checks of consent to treatment documentation (T2 and T3 forms). There were processes in place to check but these were not being completed correctly and this had not been recognised.

The service was not completing Venous Thromboembolism (VTE) risk assessments for people on admission to the hospital despite patients being admitted with clinical factors which suggested higher risk. We did not find evidence of pregnancy prevention plans for women of child bearing age prescribed sodium valproate. Awareness and implementation of good practice guidance should come from high level governance within the service to be communicated down to clinicians and managers.

Whilst there were some governance issues identified, we also noted a positive and practical management culture and a willingness to tackle issues and concerns. The service was given initial feedback about some of these issues and began to investigate and identify immediate actions and longer term plans to address these.

There was a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

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

Good 🟢

Staff undertook or participated in local clinical audits. The audits were mostly sufficient to provide assurance and staff acted on the results when needed.

Data and notifications were submitted to external bodies and internal departments as required.

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

Management of risk, issues and performance
Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was a clear quality assurance management and performance frameworks in place that are integrated across all organisational policies and procedures.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement. There was a clear decision-based management structure and schedule of meetings at which performance was discussed.

Staff maintained and had access to the risk register at facility or directorate level. Staff at facility level could escalate concerns when required.

The service operated a risk register that local managers could escalate issues to. The risk register had identified the following areas: maintenance, I.T. (WIFI) infrastructure, staff vacancies and Covid 19. There were mechanisms in place for risks to be discussed at different levels of the hospital management structure and we saw evidence of a useful flow of information between these different levels.

Staff have the ability to submit items to the provider risk register.

Staff told us that they could escalate risks and that they were kept informed of the outcome of issues that they raised. We saw evidence of performance and risk being discussed in team meetings notes.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

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

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work.

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

Good 🟢

There was an electronic patient record system. We observed staff using the system and they were all comfortable and were able to easily find information when requested. Some staff still printed out records as an easy access information point. All staff had access to the system.

Information was collected by the hospital as key performance indicators (KPIs) to provide evidence that services were compliant with targets. Performance measures were in place and were routinely reported and monitored. We saw that safety and quality dashboards were used to share information at safety and quality meetings.

This included sharing information about numbers of incidents reported, complaints and compliments received across the service. Staff told us they were provided with regular updates on performance which supported them to adjust and improve. Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

However, there had been issues for a number of years with poor wifi connectivity and poor mobile signal for patient use. The provider has attempted fixes previously but with no improvement.

Information governance systems included confidentiality of patient records.

Engagement

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

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on.

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

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

For example, we saw thematic leads such as safeguarding engaging with local safeguarding boards to establish reporting protocols.

People's views and experiences were gathered and acted on to shape and improve the service and culture. Feedback was gathered from people that use services as well as staff.

The service had recruited two former patients as volunteers who looked at community minutes for common themes and had meetings with senior managers offering advice on proposed service changes or improvements.

The hospital senior management team were engaged with the wider mental health commissioning network.

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

Good ●

Learning, continuous improvement and innovation

The organisation encourages creativity and innovation and staff had flexibility to make improvements in their own areas.

All staff have objectives focused on improvement and learning.

The service had a staff award scheme and ward based recognition schemes.

Pankhurst ward, Willows ward and Featherstone ward were members of the NAPICU accreditation scheme.

Child and adolescent mental health wards

Requires Improvement 🟠

Safe	**Requires Improvement** 🟠
Caring	**Good** 🟢
Well-led	**Requires Improvement** 🟠

Are Child and adolescent mental health wards safe?

Requires Improvement 🟠

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished and fit for purpose although not always well maintained.

Safety of the ward layout

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

Staff could not observe children and young people in all parts of the wards. The ward layouts did not allow staff to observe all parts of the ward and there were blind spots across each of the wards. Staff used regular observations and presence around the ward to mitigate these risks. The wards also had cameras and mirrors throughout the corridors and bedrooms to aid staff in managing the ward environment. Staff were aware of their responsibilities regarding this.

The ward complied with guidance on mixed sex accommodation. Meadows and Orchard were mixed sex accommodation. All children and young people had single bedrooms with ensuite facilities. Staff considered how the mixed sex environments were managed and could act if they had any concerns in relation to this.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were generally clean, well-furnished and fit for purpose, although not always well maintained.

At the last inspection of the core service in July 2021, environmental issues were identified regarding the maintenance of the ward environments. The provider had implemented a maintenance improvement plan for all wards as a result of these findings.

Child and adolescent mental health wards

Requires Improvement 🟠

We observed that actions had been taken to address most of the issues identified at the 2021 inspection with wards being redecorated. On Meadows and Woodlands, the children and young people had graffitied, scratched and chipped paint on doors and walls that had been repainted since the last inspection. This did not contribute to a pleasant environment for the children and young people and was also an infection control issue, as it would not be possible to appropriately clean these areas. It was not clear whether the provider had considered any alternative measures to prevent this from happening in the future.

On Orchard ward, we observed a patch of damp on the laundry room ceiling that had not been addressed since the last inspection. A mirror in one of the ensuite bathrooms had also been significantly scratched by a young person. These issues were reported to the ward manager.

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

Staff followed the infection control policy, including handwashing.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. Two of the three wards had seclusion rooms and all wards could access a seclusion room if it was required.

The bed and wall in the seclusion room on Woodlands had been damaged by the children and young people. Managers were aware of this damage and were waiting for repairs to be completed. The bed and walls were made of a special padded material to prevent injury from headbanging. Although the inner material was exposed, it could not be easily removed and there were not any concerns about potential ingestion of this material.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs, although issues were identified with the cleanliness of the clinic rooms and the checks of some of the equipment.

On Orchard ward, the drugs trolley was dirty, dusty and sticky. There was a sharps bin and medication destruction bin that had both not been signed or dated. There were no clean stickers on some equipment on Orchard and Woodlands. The cupboards in the Orchard ward clinic room were not organised and cluttered whilst cupboards and drawers in the Woodlands clinic room were dusty and unorganised.

There was equipment such as gloves, syringes and needles in all three clinic rooms that had expired but not been removed. These were stored alongside in date items so it was not clear to staff which equipment they should use

These issues were raised with either the ward manager or a staff member present to ensure that appropriate actions were taken to address these issues. When we raised this the ward managers were not aware of the issues as audits and clinic room checks had not identified the issues we found.

Safe staffing

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

Child and adolescent mental health wards

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. Managers monitored and reviewed staffing levels to ensure that the ward could be managed safely. Managers explained how they would access support across the hospital if staffing numbers were a concern.

The service monitored the vacancy rates of all posts. There were vacant posts for nursing and support staff on all three wards although the service was actively recruiting to these.

The service used bank and agency nurses and nursing assistants to support the wards. In the three months prior to the inspection, bank staff covered 807.2 shifts and agency staff were used to cover 732.6 shifts. These figures had increased since the previous inspection in July 2021.

Managers were aware of the challenges of using increased numbers of bank and agency staff and made attempts to limit their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Managers described how they supported staff who were off sick and were aware of the available options to support staff.

Levels of sickness were low. The hospital had over 12 months from April 2021 to March 2022 an average of 6.25% of sick leave per month. The provider was unable to split this data by ward, so it is reflective of the hospital as a whole.

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 children and young people.

The provider noted that there were 14 shifts where the wards were short of rostered numbers due to late notice of absence. The provider noted that staff from other wards could be moved to support other wards that were not at the required numbers or that managers would move into the numbers to support when required.

Children and young people had regular one to one sessions with their named nurse. Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. The provider monitored staffing levels and resource across each ward to ensure there were appropriately trained staff to attend to any incident if required.

Staff shared key information to keep children and young people safe when handing over their care to others. Staff reported that handovers were detailed, thorough and included all essential information to provide safe care and treatment to the children and young people.

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. Staff reported that they could access support when required. The provider had arrangements in place to ensure that cover was always available.

Child and adolescent mental health wards

Managers could call locums when they needed additional medical cover.

Mandatory training

The provider had taken actions to improve the mandatory training levels on Woodlands and Meadows since the last inspection. Staff on these wards had completed and kept up-to-date with their mandatory training.

On Orchard ward, staff attendance at mandatory training in Intermediate Life Support (ILS) and Reducing Restrictive Interventions Training (RRIT) were low, with ILS at 60% and RRIT at 34%. The provider confirmed that training compliance rates were being closely monitored and that staff were being booked on courses where possible, although noted that demand for face-to-face courses was currently higher than places available.

The provider told us that these two training programmes had been affected by the Covid19 pandemic and a reduction in face to face training. Whilst there had been courses routinely offered since the start of the year, attendance had been affected by staff being off work due to high numbers of community Covid19 infections and staff otherwise needing to isolate.

In mitigation, the provider told us they reviewed at each morning meeting with all the ward managers staff deployment across site and ensuring adequate training. This included the identification of staff allocated to be responders to all psychiatric and physical health emergencies throughout the hospital. Only trained and updated staff were allocated to the response team.

The mandatory training programme was comprehensive and met the needs of the children and young people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The provider employed a Site Learning Administrator that monitored training compliance rates and reported figures to senior managers.

Assessing and managing risk to children and young people and staff

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

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff were aware of when they were required to review and consider a child or young person's risk assessment. We reviewed 14 risk assessments. All children and young people had an up to date risk assessment in their care records.

Staff used a recognised risk assessment tool.

Management of patient risk

Child and adolescent mental health wards

Requires Improvement ●

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff could describe the individual risks for the children and young people. Staff were confident in managing these risks.

Staff identified and responded to any changes in risks to, or posed by, children and young people. Staff explained how they would identify any changes to a child or young person's presentation and how this would be escalated.

Staff followed procedures to minimise risks where they could not easily observe children and young people. Staff were aware of their responsibilities when observing the children and young people and what they needed to consider when doing this. Managers acted where issues or incidents were identified with a staff member's understanding of observations.

Staff followed policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were monitored by managers and fluctuated as per the acuity of the ward. Managers and staff considered where restrictive interventions had been required and ways in which these could have been prevented or reduced.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. The children and young people that had been involved in a restraint felt that they had been supported by staff following the restraint, although one young person noted one occasion they felt that they had not been supported by staff very well.

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

Staff followed the National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines. Between April 2021 and March 2022, seclusion had been used 143 times across the three wards with Meadows being the highest usage at 118 times. The use of seclusion had reduced from the 12 months prior to the previous inspection in July 2021.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was placed in long-term segregation.

Safeguarding

Staff understood how to protect children and young people 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. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Child and adolescent mental health wards

Requires Improvement ●

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. Staff received training in three safeguarding training courses. The overall compliance rates for safeguarding training for the three wards was 91% for safeguarding adults, 93% for safeguarding children and 68% for safeguarding combined.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff could describe how they considered safeguarding in their roles and were aware of their responsibilities regarding safeguarding.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were encouraged to access support from the provider's safeguarding leads and team. The service provided figures about safeguarding referrals made internally and externally that indicated that staff considered and reported safeguarding concerns across the wards.

The provider's safeguarding team had three social workers and each of these social workers had been allocated to a specific ward. These social workers acted as direct consultants for the wards on safeguarding issues or queries.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. Records were clear, up-to-date and easily available to all staff providing care. Staff were aware of how to navigate the patient records and reported no concerns about the system.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Medicines management

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

Staff generally followed systems and processes when safely prescribing, administering, recording and storing medicines, although some issues were identified. On Orchard ward, there were two medication cards which had not been completed correctly or were not clear for three days in April.

Child and adolescent mental health wards

Requires Improvement 🟠

On Orchard ward, some medication had been opened but no start or expiry date had been recorded. It was therefore not clear how staff could be assured that this medication was still safe to use.

In the Woodlands clinic room, there was an overstock of certain medications. Staff explained that this was stored for when it was needed, for example, following a self-harm incident. There was also controlled drugs stored in the controlled drugs cupboard, although none of the children and young people were currently prescribed these controlled drugs.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. The children and young people noted how staff had explained their medication to them and supported them to understand the reasons for it being prescribed.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. There was evidence in all records reviewed that staff continued to monitor the physical health of each child and young person.

Track record on safety

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff could explain what types of incidents they would report and the process they would follow to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with provider policy.

The service had no 'never events' on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full verbal explanation if and when things went wrong. The three ward managers gave examples of incidents which had met the threshold for the duty of candour and explained the actions that they had taken in respect of these incidents. However, the provider's verbal apologies and explanations had not been followed up by a written summary for the three examples given.

Child and adolescent mental health wards

Requires Improvement ●

Managers debriefed and supported staff after any serious incident. Staff confirmed that debriefs took place after incidents although did note that this could be difficult when the ward was busy.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers gave feedback to staff on incidents and lessons learned during team meetings.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Managers and staff could give examples of where learning from incidents had resulted in changes to practice to improve patient care. For example, staff held a meeting to discuss a young person who was frequently self-harming in a certain way at night. Staff considered if these incidents could be managed in a different way and developed a plan to do so.

Are Child and adolescent mental health wards caring?

Good ●

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for children and young people. We observed interactions between staff and the children and young people where staff took the time to listen to and consider their needs. The children and young people mostly gave positive feedback about the staff on the wards and said that they provided appropriate care and treatment. One young person noted that the ward had not been what they were expecting and that it felt like a family on the ward.

Staff gave children and young people help, emotional support and advice when they needed it. The children and young people reported that they generally felt supported by staff and safe on the wards.

Staff supported children and young people to understand and manage their own care treatment or condition. Staff and managers explained how they involved the children and young people in their care and treatment. Children and young people were invited to and included in meetings regarding their care and treatment. The children and young people gave examples of when staff had taken the time to explain aspects of their care and treatment to help them have a better understanding.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Child and adolescent mental health wards

Requires Improvement ●

Children and young people said staff treated them well and behaved kindly. Children and young people were generally positive about how staff treated them on the wards although two young people commented that not all staff were as good as others. One young person felt that staff were not always responsive and respectful.

Staff understood and respected the individual needs of each child or young person. Staff had a good understanding of the children and young people that they were caring for.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that children and young people had easy access to independent advocates and to child helplines.**

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. Staff explained how children and young people would be supported on arrival to the ward and introduced to their surroundings. The children and young people confirmed that they had been supported during their admission and had been introduced to the ward.

Staff involved children and young people and gave them access to their care planning and risk assessments. Staff included children and young people in their care plans and offered them copies, although these were not always accepted. Staff documented when care plans had either been given or offered to the children and young people.

Staff made sure children and young people understood their care and treatment. Staff explained how they would support children and young people in understanding their care and treatment. Staff involved patients in meetings about their care and treatment and ensured that the children and young people had a voice during these.

Staff involved children and young people in decisions about the service, when appropriate.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The wards held regular community meetings that the children and young people could attend to voice their opinion and views about the ward. The minutes of these meetings indicated that the children and young people felt confident in raising any concerns about the ward.

Staff supported children and young people to make decisions on their care. Staff offered the children and young people the chance to prepare for meetings about their care and treatment to ensure that their feelings and opinions were considered. The children and young people mostly felt involved about decisions relating to their care and treatment.

Staff made sure children and young people could access advocacy services. The children and young people reported that they were aware of how to access advocacy services and had done so on the ward. Staff explained how they ensured that the children and young people were aware of the advocacy services.

Child and adolescent mental health wards

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff explained how they maintained contact with families and carers during a young person's stay at the service. Staff shared information about the young person's care and treatment with their families and carers in line with the young person's wishes. Each ward had an individual parent and carer welcome pack that was provided to families to introduce them to the ward and the service.

Staff helped families to give feedback on the service. Families and carers were invited to a monthly support group to speak about their experiences. Any feedback or concerns raised in the group were shared with the wards.

Staff gave carers information on how to find the carer's assessment.

Are Child and adolescent mental health wards well-led?

Requires Improvement ●

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

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 children, young people, families and staff.

The ward managers and interim ward manager were skilled and had the knowledge to perform their roles. One of the ward managers had been appointed to their post six months prior to the inspection.

Staff told us they were visible, approachable and supported them in their day to day tasks. They were willing to get involved in day to day work where needed to support staff and children and young people to deal with difficult situations. Staff reported feeling valued by their manager and they received regular feedback. Ward managers could explain clearly how the teams were working to provide high quality care.

The hospital director had returned their office to its original location next the entrance hall directly opposite reception. This meant that all staff and visitors passed their office door when entering and exiting the hospital. Staff we spoke to all mentioned that they had an open-door policy and that they were extremely visible.

Staff were supported and encouraged to take on more senior roles. Hospital managers worked with staff to implement development plans. They told us they had succession plans in place to upskill staff to become leaders or more senior practitioners in the event of staff leaving. For example, staff were encouraged to complete leadership courses.

Vision and strategy

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

Child and adolescent mental health wards

Senior hospital managers, ward managers and staff all referred to Cheadle Royal as somewhere they were proud to work. The phrase "Cheadle family" was often used. Ward managers promoted the behaviours that Priory aspires too. Putting people first, being supportive, acting with integrity, striving for excellence and being positive.

Culture

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

Staff felt supported, respected and valued. Staff were passionate about their jobs and the care and treatment that they delivered to the young people. Staff were generally positive about working for the service and felt part of the wider organisation. Leaders within the service spoke highly of their team. The teams worked well together and there was a positive staff culture.

Behaviours were included in staff appraisals as well as developmental opportunities.

Staff told us they felt the service had an open culture where they could raise concerns without fear. Those that had raised concerns felt listened to and that action had been taken. Staff were aware of the whistle-blowing process and where to find the policy.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Issues identified with the clinic rooms and medications did not indicate that governance processes were always effective at addressing areas of concern or issues. These issues had not been identified during the provider's own checks and audits.

The provider had taken actions to address the environmental issues identified at the previous inspection in July 2021, although issues were still present. A damp patch on the ceiling of the laundry room at Orchard ward remained since the previous inspection. It was reported that the ceiling had been repainted since the last inspection, however, the damp patch looked worse than in July 2021 and more paint was flaking off the patch.

On Woodlands, a new process had been implemented where certain types of leave such as group trips, may be limited for a young person depending on their attendance and engagement with education. There was evidence in the community meetings that this process had been introduced to the young people, however, there was no formal process or policy written down and therefore could be considered a blanket restriction. It was not clear as to how managers were assured that staff were aware of what the process was. There had also been no formal review or planned review of this process to evaluate its effectiveness, although it was reported that attendance at education had improved.

A new hospital manager had been appointed since the last inspection in July 2021. They had maintained the governance structure which had an overarching clinical governance committee chaired by either the hospital or medical

director. There were another eight sub-committees that reported directly to the committee. They covered the core services and thematic issues such as safeguarding, infection control, risk and restrictive practice, medicine management, staff engagement, health and safety and quality. These sub-committees included members from ward-based staff.

We saw that there was a clear framework for team meetings with a set agenda which ensured that information, such as learning from incidents and complaints, was shared and discussed.

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.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement. There was a clear decision-based management structure and schedule of meetings at which performance was discussed.

The service operated a risk register that local managers could escalate issues to. The risk register had identified the following areas, maintenance, I.T. (WIFI) infrastructure, staff vacancies and Covid-19. There were mechanisms in place for risks to be discussed at different levels of the hospital management structure and we saw evidence of a useful flow of information between these different levels.

Staff told us that they could escalate risks and that they were kept informed of the outcome of issues that they raised. We saw evidence of performance and risk being discussed in team meetings notes.

Senior leaders were aware of the risks within the service and these were reviewed within quality review boards.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

Information management

Staff engaged actively in local and national quality improvement activities.

There was an electronic patient record system. We observed staff using the system and they were all comfortable and were able to easily find information when requested. Some staff still printed out records as an easy access information point. All staff had access to the system.

Information was collected by the hospital as key performance indicators (KPIs) to provide evidence that services were compliant with targets. Performance measures were in place and were routinely reported and monitored. We saw that safety and quality dashboards were used to share information at safety and quality meetings.

This included sharing information about numbers of incidents reported, complaints and compliments received across the service. Staff told us they were provided with regular updates on performance which supported them to adjust and improve. Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

Child and adolescent mental health wards

Requires Improvement ●

Engagement

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

For example, we saw thematic leads such as safeguarding engaging with local safeguarding boards to establish reporting protocols.

People's views and experiences were gathered and acted on to shape and improve the service and culture. Feedback was gathered from people that use services as well as staff.

The service had recruited two former patients as volunteers who looked at community minutes for common themes and had meetings with senior managers offering advice on proposed service changes or improvements.

The hospital senior management team were engaged with the wider mental health commissioning network.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff did not use specific quality improvement methods. Leaders encouraged innovation and participation in research.

All wards were engaging with the Quality Network for Inpatient CAMHS (QNIC) and aspired to achieve QNIC accreditation. Managers had plans in mind that would support the wards in achieving this accreditation.

Staff and managers were engaged with identifying areas of practice that could be improved on their ward and there were examples of innovation that had been implemented since the last inspection. On Woodlands, staff had implemented vocational roles for the young people on the ward including roles such as a barista and librarian. These roles encouraged engagement and interactions for the young people, along with teaching them about the responsibilities and expectations of having a job.

Specialist eating disorder services

Good 🟢

Safe	**Good** 🟢	
Well-led	**Good** 🟢	

Are Specialist eating disorder services safe?

Good 🟢

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

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff carried out preventative monitoring throughout the premises including statutory testing (e.g. fire alarms) and environmental monitoring.

Staff could not observe patients in all parts of the wards due to the ward layout. However, staff used regular observations in line with patients' risk assessments to reduce the risks. The service had two wards Cedar and Aspen, and there was agreed after meal support in the ward lounges.

The wards provided mixed sex accommodation which complied with national guidance. The dignity and privacy of all patients was upheld.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Both wards had recent ligature risk assessments that reflected the environment. These were updated following changes to the ward environment.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were regularly checked, and action taken when issues were identified.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. There was an onsite maintenance team and a system for reporting maintenance work in a timely manner.

We observed the wards were quiet and calm.

Staff and patients carried out a Patient-Led Assessments of the Care Environment (PLACE). We saw evidence that environmental changes were discussed regularly in community meetings.

Specialist eating disorder services

Staff made sure cleaning records were up-to-date and the premises were clean. Changes had been made to the cleaning schedule due to Covid-19 to enhance cleanliness. Patients told us they thought both wards were well maintained and we saw that all areas were clean.

Staff followed infection control policy, including handwashing. Staff followed the infection control policy specific to Covid-19 and lessons learnt from Covid-19 outbreaks elsewhere in the hospital had been shared with staff.

Seclusion room

There was no seclusion room at the site.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. On the last inspection we found that the defibrillator machines and weighing scales had not received an annual service in line with the providers policy, therefore staff could not guarantee that this equipment would work as required. However, on this inspection all equipment had been serviced and maintained.

Medicines were stored appropriately and did not exceed expiry date.

Staff checked, maintained, and cleaned equipment. Both clinic rooms were tidy. Staff recorded daily room temperatures and fridge temperatures and knew what actions to take if these were out of range. Nurses had access to equipment for monitoring physical observations which was regularly cleaned and maintained.

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. The service had 16.07 whole time equivalent nurses and 43.09 health care assistants. Both patients and staff felt there were enough staff to provide safe, good quality care.

The service had increasing vacancy rates. At the last inspection the service employed 72.17 whole time equivalent staff and had vacancies for 1.73 nurses and 2.6 healthcare assistants. They now had a reduced number of staff at 59.16 with greater vacancies for nurses (3.93 vacancies) and healthcare assistants (24.72 vacancies). The service had an ongoing recruitment campaign and held interviews regularly.

The service had increasing rates of bank and agency nurses and healthcare assistants. Bank staff worked permanently on the wards and they had covered 1680 shifts over the last 12 months with agency staff covering 1765 shifts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. All staff who worked on the bank rota were Priory staff and had experience of working on the wards, and agency staff were pre-booked to ensure continuity.

Specialist eating disorder services

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had similar turnover rates for nurses but an increased turnover rate for healthcare assistants. In twelve months from April 2021 to March 2022 there had been a 20% turnover of nurses and turnover of healthcare assistants had increased from 22.5% to 30% for the hospital. They were unable to provide information for the eating disorder service but all staff we spoke with felt the staff were settled. However, a number of healthcare assistants had left the service.

Managers supported staff who needed time off for ill health.

Levels of sickness were low. The service had over 12 months from April 2021 to March 2022 an average of 6.25% of sick leave per month.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The service lead could adjust staffing levels according to the needs of the patients. Additional staff could be requested if there were more patients on observations, or higher levels of observations than assumed within the staffing establishment.

Patients had regular one-to-one sessions with their named nurse. These sessions discussed areas of their care plan and any concerns they had. This was monitored within the ward clinical audit process. Patients spoke highly about their named nurses and all felt they had time to discuss their progress.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. This included where staff were required to restrain patients to enable them to administer nasogastric feeding. These were planned with the patient and documented within their care plan.

Both wards had the support of a full time dietitian, an occupational therapist, family therapist and psychological support. The therapeutic weekly activity programme included the Maudsley Model of Anorexia Nervosa Treatment in Adults (MANTRA). The service had introduced a new role within the dining rooms to increase the support at meal times.

Staff shared key information to keep patients safe when handing over their care to others. We saw staff had daily briefing sheets providing them with information about the patient and any changes to risk.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the wards quickly in an emergency.

Managers could call locums when they needed additional medical cover. The service employed two consultant psychiatrists and a speciality doctor.

Managers made sure all locum staff had a full induction and understood the service before starting their shifts.

Mandatory training

Specialist eating disorder services

Staff had completed and kept up-to-date with their mandatory training. Ninety five percent of staff had completed mandatory training. The course with the lowest completion rates was immediate life support at 87.5%.

The mandatory training programme was comprehensive and met the needs of patients and staff. All staff had also received specialist autism training.

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

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were reviewed on a weekly basis during multi-disciplinary team meetings. The risk assessments documented in care records were thorough and included both historical and current risks.

Staff used a risk assessment tool which incorporated the risk assessment framework from the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. We examined 11 patient risk assessments and all were of good quality; staff were aware of patient risks and could talk about these in great detail. Patients felt staff were supportive and understood their needs.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff used regular observations in line with patients' risk assessments to reduce risks and reviewed these observation levels regularly to reduce them when safe to do so. We saw examples where patients' risk and observation plan had been changed as the result of an incident.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions varied between wards. Aspen reported 30 restraints while Cedar reported 200 restraints in 12 months, which included restraints to support patients with nasogastric feeds. There were no incidents of rapid tranquilisation or seclusion. Cedar ward had accepted patients who presented with more complicated needs.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Specialist eating disorder services

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff used a range of highly personalised strategies to support patients during nasogastric feeds to reduce the need for restraint. We saw evidence that the use and methodology of restraint nasogastric feeding had been reviewed by the hospital lead on restraint.

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

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

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. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Safeguarding training for both adults and children had been completed by 95.5% of staff.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. In six months from October 2021 to April 2022 staff reported 85 incidents for safeguarding to the internal hospital safeguarding team.

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

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the safeguarding lead for the hospital and knew how to make an online safeguarding referral and to which local authority it needed to be made. Staff told us they had a very helpful internal safeguarding team that would support them with more complicated cases.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. All patient records were kept on an electronic recording system which was accessible for all staff. Staff said the system was easy to navigate with all patient information available to them.

The service used a combination of electronic and paper records. All the electronic care records and paper-based Mental Health Act records we reviewed were up-to-date and complete.

When patients transferred between wards, there were no delays in staff accessing their records.

Specialist eating disorder services

Good ●

Records were stored securely.

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.

We reviewed 10 prescription charts.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The provider had a contract with a specialist pharmacy provider who delivered medicines on a stock basis for all patients in the hospital.

The provider had policies for medicines management, and these were followed by staff. Medicines were dispensed from and stored securely in the ward clinic rooms and stock rotation, transport and storage were in line with procedural guidance.

Regular audits were in place and the pharmacist visited weekly.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw evidence of medication discussions in patient records and capacity documents were well completed outlining medicines discussions.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines were regularly reviewed, including as required medicines. The pharmacist also completed a weekly stock check and audit and highlighted any areas in a report for managers to action.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. All records noted patient allergies.

Track record on safety

Reporting incidents and learning from when things go wrong

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

Specialist eating disorder services

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

Staff identified and knew how to report most incidents. The current presentation of the patient population in Cedar and Aspen was reflected in the incident figures. Aspen had 288 incidents while Cedar reported 405 incidents in 12 months. There was a small number of complex patients about whom incidents such as nasogastric feeds had been recorded.

All staff we spoke with said they reported anything they considered a reportable incident in line with the hospital policy and were encouraged and supported to do so by their managers.

Staff raised concerns and reported incidents and near misses in line with provider policy. All staff that we spoke to talked confidently about what types of things should be reported and how they would report them. They told us that information was shared with them via regular team meetings, which we saw evidence of and during regular staff huddles and handovers.

The service reported 18 serious incidents: seven were patients transferred to hospital for conditions related to eating disorders, five were admission for other reasons and three were for patients absconding. Other incidents included police attendance, issues with mental health act paperwork and a reported safeguarding issue.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong. There had been three incidents requiring a duty of candour response. These included two about complaints regarding nasogastric feeding and the third regarding family visits. The hospital used the duty of candour response system for incidents below that threshold to apologise to patients and family.

Managers debriefed and supported staff after incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

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 were able to give us examples of incidents being shared in reflective practice and staff meetings, as well as information brought back to them as a result of investigations.

There was evidence that changes had been made as a result of feedback.

Managers shared learnings with their staff about 'never events' that happened elsewhere.

Are Specialist eating disorder services well-led?

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

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

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

Specialist eating disorder services

The ward managers were experienced and skilled and performed their role well. Staff told us they were visible, approachable, listened and supported them in their day to day tasks. They were willing to get involved in day to day work where needed, to support staff and patients to deal with difficult situations. Staff reported feeling valued by their manager and received regular feedback. Ward managers could explain clearly how the teams were working to provide high quality care.

The hospital director had returned their office to its original location next to the entrance hall, directly opposite reception. This meant that all staff and visitors passed their office door when entering and exiting the hospital. Staff we spoke to all mentioned that he had an open-door policy and that he was extremely visible.

The eating disorder service had implemented a new staff rota calculation system which now incorporated extra duties such as nasogastric feeding when calculating now many staff were required on each ward.

Staff were supported and encouraged to take on more senior roles. Hospital managers worked with staff to implement development plans. At the last inspection we were told of plans to increase the number of dieticians and these had now been recruited.

Vision and strategy

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

Senior hospital managers, ward managers and staff all referred to Cheadle Royal as somewhere they were proud to work. The phrase "Cheadle family" was often used. Ward managers promoted the behaviours that Priory aspires to. Putting people first, being supportive, acting with integrity, striving for excellence and being positive.

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 were very positive about working for the service and felt part of the wider organisation. Leaders within the service spoke highly of their team. The team worked well together and there was a positive staff culture.

Behaviours were included in staff appraisals as well as developmental opportunities.

All staff, patients and carers told us they felt the service had an open culture where they could raise concerns without fear. Those that had raised concerns felt listened to and that action had been taken. Staff were aware of the whistle-blowing process and where to find the policy.

Governance

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

A new hospital manager had been appointed since the last inspection in July 2021. They had maintained the governance structure which had an overarching clinical governance committee chaired by either the hospital or medical

Specialist eating disorder services

director. There are another eight sub-committees that reported directly to the committee. They covered the core services and thematic issues such as safeguarding, infection control, risk and restrictive practice, medicine management, staff engagement, health and safety and quality. These sub-committees included members from ward-based staff.

We saw that there was a clear framework for team meetings with a set agenda which ensured that information, such as learning from incidents and complaints, was shared and discussed.

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.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement. There was a clear decision-based management structure and schedule of meetings at which performance was discussed.

The service operated a risk register that local managers could escalate issues to. The risk register had identified the following areas: maintenance, I.T. (WIFI) infrastructure, staff vacancies and covid 19. There were mechanisms in place for risks to be discussed at different levels of the hospital management structure and we saw evidence of a useful flow of information between these different levels.

Staff told us that they could escalate risks and that they were kept informed of the outcome of issues that they raised. We saw evidence of performance and risk being discussed in team meetings notes.

Senior leaders were aware of the risks within the service and these were reviewed within quality review boards.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

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

There was an electronic patient record system. We observed staff using the system and they were all comfortable and were able to easily find information when requested. Some staff still printed out records as an easy access information point. All staff had access to the system.

Information was collected by the hospital as key performance indicators (KPIs) to provide evidence that services were compliant with targets. Performance measures were in place and were routinely reported and monitored. We saw that safety and quality dashboards were used to share information at safety and quality meetings.

This included sharing information about numbers of incidents reported, complaints and compliments received across the service. Staff told us they were provided with regular updates on performance which supported them to adjust and improve. Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

Specialist eating disorder 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 clients nationally. Managers from the service participated actively in the work of the local transforming care partnership.

People's views and experiences were gathered and acted on to shape and improve the service and culture. Feedback was gathered from people that use services as well as staff.

The service had recruited two former patients as volunteers who looked at minutes from community meetings for common themes and had meetings with senior managers offering advice on proposed service changes or improvements.

There was now an online carers group which included education for carers about eating conditions and the effects they had on loved ones.

The hospital senior management team were engaged with the wider mental health commissioning network. The eating disorder order service was an active member of the national quality network for eating disorders. Consultant psychiatrists were regional representatives for the Royal College of Psychiatrists in the North West.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff did not use specific quality improvement methods. Leaders encouraged innovation and participation in research.

Nursing staff were receiving training from the psychology team so they had a greater understanding of the sessions being undertaken by patients.

Requirement notices

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.

This section is primarily information for the provider

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance Acute wards for adults of working age and psychiatric intensive care units • In acute wards there was not sufficient oversight of processes for checking equipment and ward-based audits, physical health assessment, monitoring, Venous Thromboembolism (VTE) risk assessments and pregnancy prevention plans for women of childbearing age prescribed sodium valproate. • The service must address concerns raised about night staffing and negative cultures. Child and adolescent mental health wards • The hospital's governance processes had not ensured that the issues regarding the clinic rooms and medications were addressed in a timely and appropriate manner.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The service had not ensured that clinic rooms were checked and maintained appropriately.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Requirement notices

- We found doors that had been graffitied by patients who had chipped away the paint and this damage had not been addressed. It was not clear that any measures were in place or had been considered to prevent this from happening in the future. A damp patch on the ceiling of the laundry room on Orchard ward had not been addressed since the last inspection.