Partnerships in Care Limited

Priory Hospital Burgess Hill

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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We carried out a focused unannounced inspection on 5 and 7 May 2021 of two wards at Priory Hospital Burgess Hill. We inspected the female specialist personality disorder ward (Amy Johnson) and the forensic low secure inpatient ward (Michael Shepherd). We specifically looked at some aspects of the key questions of safe, effective and well-led, because of concerning information we had received about patient safety.

During the inspection we found a number of areas of concern. Following this inspection, we wrote to the provider and told them that we required them to provide us with assurance that they would make immediate and ongoing improvements, otherwise we would use our powers under Section 31 of the Health and Social Care Act 2008. Section 31 of the Act allows CQC to impose conditions on a provider's registration. The provider responded to us and provided an action plan that told us what they would do to address our concerns. In addition, the provider decided to close two hospital wards (the female psychiatric intensive care and female personality disorder wards) in order to ensure they could staff the three remaining wards safely.

CQC reviewed the provider's action plan and felt that the actions the provider was taking reduced the risks sufficiently enough that urgent enforcement action was not necessary. However, CQC will continue to closely monitor the hospital on a weekly basis until the risk had further reduced.

Following our inspection, we suspended the ratings for the hospital. Due to the closure of two wards the ratings were no longer a true reflection of the service provided. We will return to inspect the hospital in due course and rate the hospital accordingly.

We found:

• The wards we inspected did not have enough experienced and skilled staff to manage all the risks on the wards. The service had high vacancy rates and used many agency staff. This meant that there were not enough staff who knew the patients well enough to keep them safe from avoidable harm.

• Staff did not assess and manage risk well. Staff were not consistently undertaking risk assessments of all patients' identified risks and they did not clearly identify the severity of these risks.

• The levels of restrictive practices on Amy Johnson ward were high. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.

• Staff did not always develop holistic, recovery-oriented care plans and engage in audit to evaluate the quality of care they provided. This meant that care plans did not always reflect patients' assessed needs and were not personalised.

• The service did not always ensure that information about patient behaviours was effectively shared between all staff. Sometimes staff did not have access to patients' care plans and risk assessments due to frequent problems with the electronic system. Staff that did not regularly work at the hospital did not have log in details, so they could not easily access patient information.

• Governance processes were not always robust enough to identify issues around lack of coordination between the various systems and processes and to facilitate effective risk management. The service did not always capture and act

Summary of findings

on patient feedback. Multidisciplinary team meetings did not thoroughly and effectively discuss patient safety and risk management. There was no evidence or clear process of how incidents were recorded, investigated and learning shared. This meant that the provider did not always know whether staff were delivering safe care that met individual needs.

However:

• Staff provided a range of treatments such as dialectical behavioural therapy and cognitive behavioural therapy suitable to the needs of the patients cared for in the Amy Johnson rehabilitation ward.

• Leaders had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for patients and staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inspected but not rated	During the inspection we found: • Managers did not always ensure that staff were competent and skilled to manage the risks on the ward. Some patients told us that staff did not have enough available time to spend with them and several reported that often the ward did not have a registered nurse during night shifts. • Staff did not assess and manage risk well. They did not develop effective risk management plans and follow effective risk management protocols in both the delivery of routine care, and in situations where staff were managing the risks to patients following incidents. Staff did not minimise the use of restrictive practices. • The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. • Staff did not always have access to patients' care plans and risk assessments due to frequent problems with the electronic system. Staff that did not regularly work at the hospital did not have log in details, so they could not easily access patient information. • Staff did not always identify patients' physical health needs and recorded them in their care plans. Patients did not always have their physical health regularly reviewed and physical health observations were not always followed through. • Multidisciplinary team meetings did not thoroughly and effectively discuss patient safety and risk management. Risks and patients' needs were not discussed holistically with input from all members of the multidisciplinary team. Lessons from incidents were not followed through and shared with the team. • Governance processes did not ensure that ward procedures ran smoothly and did not identify issues around lack of coordination between the various systems and processes in place. However:

Summary of findings

			• Staff ensured that patients had access to psychological therapies such as dialectical behavioural therapy and cognitive behavioural therapy.
Forensic inpatient or secure wards	**Inspected but not rated**		During the inspection we found: • The service did not always have enough skilled, experienced and competent staff. The service was using a high number of agency staff that did not know the patients or understood their risks. • Staff did not assess and manage risk well. Staff were not consistently undertaking risk assessments of all patients' identified risks and they did not clearly identify the severity of these risks. Patients care plans were not always individualised and did not always have specific interventions. Staff could not always access patients' care records because of IT problems. • The service's overall clinical governance was not robust enough in reducing and managing risks. There were no clear processes for how incidents were managed and how patients' concerns were addressed. However: • Staff used recognised rating scales to assess and record the severity of patients' conditions. • Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Summary of findings

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Background to Priory Hospital Burgess Hill

The Priory Hospital Burgess Hill is a purpose-built hospital providing assessment and treatment in acute and psychiatric intensive care units, as well as low secure services and long stay rehabilitation services for people with mental health needs. At the time of the inspection there were seven patients on Amy Johnson ward, two of them were receiving treatment in an acute hospital, and there were 11 patients on Michael Shepherd ward. The hospital had five open wards and one closed for refurbishment. These included:

• Elizabeth Anderson, a female psychiatric intensive care unit with 10 beds.

• Amy Johnson, a female specialist personality disorder unit with 10 beds.

• Michael Shepherd, a female low secure unit with 16 beds.

• Wendy Orr, a male psychiatric intensive care unit with eight beds.

• Edith Cavell, a mixed gender acute service with 16 beds.

• Helen Keller was closed for refurbishment.

Priory Hospital Burgess Hill was last inspected in August 2020. This was an unannounced, focused inspection of the psychiatric intensive care ward (Elizabeth Anderson) and the forensic low secure inpatient ward (Michael Shepherd) and we focussed on areas of the key question of safe. During the inspection, we identified concerns and issued requirement notices to the provider related to concerns around safe care and treatment, need for consent and staffing. Following this inspection we rated the key question 'are services safe' as requiring improvement.

The hospital last had a comprehensive inspection in April 2019. We rated the service good overall and good in all domains.

The hospital is registered to provide the following regulated activities:

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

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

A new hospital director had commenced employment with the service in April 2021 and will be applying to become the registered manager with the Care Quality Commission.

What people who use the service say

We had mixed reports from patients on the Amy Johnson ward. Some patients told us that they were happy on the ward and felt positive about the dialectical behaviour therapy programme. Some others told us that they felt anxious and

Summary of this inspection

stressed because it was often unsettled and chaotic on the ward. Some patients told us there were punitive measures and too many restrictions in place on the ward, which patients felt were used as a way of punishing them. Some patients also felt that there was little time available for staff to spend with them and they reported that often the ward did not have enough qualified staff, especially during night shifts.

We had mixed reports from family members of patients on the Amy Johnson ward. Some of the them told us that patients felt safe, staff did a good job and that the service had enough staff to support patients. Some others told us that they were concerned about low staff numbers, there was poor communication with the hospital, activities were cancelled, and they did not have the opportunity to provide feedback about the service.

On Michael Shepherd ward, patients told us that staff were always in the office and hardly in the communal areas. They told us that there was never enough staff around and staff did not always check on them at night. Patients told us that there were not a lot of activities on the ward, and some of the activities were not meaningful.

Patients' family members we spoke with told us that patients did not do much, although they have a gym. One family member told us they were not involved in patients care.

How we carried out this inspection

The team that inspected the hospital comprised five CQC inspectors, one specialist advisor and one expert by experience who undertook interviews with patients and carers remotely.

Before the inspection visit, we reviewed information that we held about the hospital.

During the inspection, we spoke with the hospital director, ward managers, doctors and other staff members, including members of the multidisciplinary team, nurses and health care assistants. We also spoke with patients who used the service and some family members.

We looked at electronic and paper copies of care and treatment records of patients and reviewed a range of documents relating to the running of the service. We also observed a multidisciplinary team meeting and handovers.

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

Areas for improvement

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

We told the provider that they MUST take the following actions:

• The provider must ensure that all staff are always able to access and follow patients' care plans and risk assessments, in order to provide care and treatment to patients in a safe way (Regulation 12, of the Health and Social Care Act 2008 (RA) Regulations 2014).

Summary of this inspection

• The provider must ensure that there are effective governance processes in place to support good quality of care delivery and ensure there is clear oversight of care by leaders of the hospital, so action can be taken quickly to make improvements. (Regulation 17, of the Health and Social Care Act 2008 (RA) Regulations 2014).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Long stay or rehabilitation mental health wards for working age adults	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Forensic inpatient or secure wards

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Forensic inpatient or secure wards safe?

Inspected but not rated

Safe staffing

The service did not always have the right staff with the right skills to keep patients safe from avoidable harm. The general feedback from staff at all levels was that there were challenges with staffing including retention, recruitment and skill mix. Managers tried to reduce patient risks by block-booking bank and agency staff that were familiar with the service, however this was not always possible. The service was using a high number of agency staff that did not know the patients or understood their individual risks. There had been several reported incidents where there were no qualified nursing staff on shift as shown in their monthly quality report. There had been a significant number of self-harm related incidents where patients had access to items that could cause them harm.

During our inspection on Michael Shepherd ward, that there was one registered nurse on shift although they were meant to have two registered nurses. Staff told us this happened frequently.

The service was reporting a high vacancy rate for both registered nurses and healthcare assistant at 87.5% and 62.5% respectively. The service depended mainly on agency staff for both nursing and medical cover.

Following our inspection in August 2020, we raised concerns about the high vacancy rates, and the high use of agency staff and that patients told us these staff did not always know who they were, or how to meet their needs, which impacted upon the consistency of care available to patients and the hospital's ability to safely manage some risks, such as self-harm. On this inspection we saw there had not been any improvement, and the vacancy rates for nursing staff had increased.

Assessing and managing risks to patients and staff

Staff did not ensure patients risks were consistently reviewed and updated, in a systematic and timely way. On three of the six patient records we reviewed, there were no clear rationale for how risks were reviewed and what actions staff were taking to reduce or mitigate their risks. We saw that staff had not reviewed the risks for a patient following two separate incidents of deliberate self-harm and attempted ligature. Another patient who was a noted as high risk for non-adherence to treatment, self-harm and exploitation of others, was not reviewed by staff for three days following a serious incident. Staff were unaware that a patient who was newly admitted had not eaten any solid food for at least five days since their admission, and that the patient had been drinking only coffee and cola during this time. We could not find records that this had been escalated to the appropriate teams.

Track record on safety

Inspected but not rated

Forensic inpatient or secure wards

The service was reporting a high number of incidents, which meant staff did not always keep patients safe. Between January and April 2021, there had been 254 reported incidents on Michael Shepherd ward which were related to staffing, self-harm and violence and aggression.

The themes from the incidents showed that there was pressure on staffing. For example, one incident occurred when staff from the hospital and agency staff restrained a patient. The process did not follow usual protocols because the different staff had varying levels of training and understanding. This led to the patient sustaining an injury.

Are Forensic inpatient or secure wards effective?

Inspected but not rated

Assessment of needs and planning of care

Patients care plans were not always individualised and did not always have specific interventions. We saw on five out of six patient records that care plans were basic, and it was not always clear what the patient's contributions were. For example, one patient record showed staff were changing patients wound but there was no clear care plan around how frequently the dressing should be changed, no details of date of next dressing change, and no details of the description of the wound. Another patient who was a risk of arson did not have a care plan around lighters and matches when they returned from leave.

Skilled staff to deliver care

Occupational therapy staff only worked four weekdays 8am to 4pm, and there were very limited activities for patients in the evenings and on weekends. Out of the four patients we spoke with two of them told us there wasn't enough activities for them to do as there was often not enough staff to facilitate this.

Best practice in treatment and care

Staff were not always able to access patients' care plans and risk assessments on the electronic system due to frequent problems with IT systems. We could not access patient care records on the day of inspection as the systems had failed and there were no backup copies of patient records. We had to reschedule a visit for another day in order to look at patient care records and on that day the system was very slow.

Staff told us problems with the IT systems was an ongoing concern and that the systems were persistently slow. Staff told us they often have to come in very early to work to be able to use the systems. Staff told us it was common practice for them to work extended hours unpaid in order to complete critical tasks. New members of agency staff and those that did not work regularly at the hospital were not given access to care records. This meant that staff may not be aware of patients' individual needs and risks to provide appropriate care and support to them.

Staff used recognised rating scales to assess and record the severity of patients' conditions.

Are Forensic inpatient or secure wards well-led?

Inspected but not rated

Forensic inpatient or secure wards

Inspected but not rated

Leadership

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

The hospital had recently recruited a new hospital director who had identified some main areas of improvement at the hospital and was putting together an action plan, which included actions taken to immediately address challenges with staffing. The hospital director and senior leaders told us that they had paused admissions and were proposing to close two wards and redeploy staff, to help stabilise the skill mix and improve quality of care.

Governance

The service's overall governance processes were not robust enough to facilitate effective risk management. Although the service maintained a register of risks, there were risks that have been recorded since 2019 and it was not clear the actions the provider had taken to address these risks.

The service did not always ensure they capture and act on patient feedback. Community meeting records we reviewed between February and April 2021 showed that this did not always happen, and when they did, staff did not take action to address concerns. For example, patients had raised concerns about lack of activities on the wards especially on weekends and also complained about staffing, but it was unclear how this was being escalated and addressed.

There was no evidence or clear process of how incidents were recorded, investigated and learning shared. We reviewed monthly business meeting minutes, and these showed the number of incidents but no detail of the incident or trends. In the feedback section it stated that information was fed back in meetings, but this was not reflected in the meeting minutes. A lot of the actions in these minutes stated 'to be confirmed' as did the action owner section. Most of the information were recorded in a graph format which was difficult to understand, and they lacked detail.

Staff meetings were not regular, purposeful, and lacked detail of how they would improve service delivery. We reviewed four minutes of meetings from January 2021, and saw they were very brief and lacked detail. There was no evidence of lessons learnt being shared. The meetings generally lacked actions and accountability or updates on actions from previous meetings. Staff told us that the meetings were supposed to be done weekly but had not been regular.

Managing of risks, issues and performance

There were no clear processes for how risk, issues and performance were managed. Staff told us they did not have appraisal of their work in line with policy. Agency staff that did not work regularly at the hospital, did not always have access to patient care records and risk assessments.

The provider had placed the hospital on their 'watch list' which was intended to provide greater support and leadership oversight, but we were not assured this was effective and staff we spoke to could not identify any benefits. Staff told us some senior leaders had visited the hospital and had have meetings with the teams, but these have not been productive as they were not very meaningful, and the meetings lacked clear direction.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

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

Inspected but not rated

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients well enough to keep them safe from avoidable harm. The service had high vacancy rates and high rates of agency nurses. Managers could adjust staffing levels according to the needs of the patients, however, they had to mostly rely on agency staff who were not always effectively managing the risks on the ward because they did not know the patients well and could not always access the patients records. Senior staff described considerable challenges with staffing, including difficulties with retention, recruitment and maintaining the appropriate skill mix. The provider had calculated that 7.2 fulltime equivalent registered nurses were needed for the Amy Johnson ward, but there was only one permanent registered nurse. Some patients told us that staff did not have enough available time to spend with them and several reported that often the ward did not have a registered nurse during night shifts. The senior team was working to identify solutions to this. However, the senior team at the hospital had to use Priory centralised policies for recruitment and the onboarding of agency staff, which staff told us were unsuitable for local circumstances. Staff told us that this should be organised by ward managers who better understand the needs of the wards.

Senior staff described challenges in attracting locum doctors to the service and told us that for the previous six months they had been unable to recruit any locum junior doctors. This significantly increased the workload for consultants despite the senior team's willingness to accept doctors from a variety of grades. During the inspection we were informed that the hospital had vacancies for two junior doctors. While recruitment was completed, the new recruits could not start work until delays in issuing work visas were resolved.

Some staff worked extended hours to meet the basic needs of the service. For example, some members of the multidisciplinary team told us that they routinely started work early so they could attend handovers or worked extra hours every day to complete the most critical tasks.

Assessing and managing risks to patients and staff

Staff did not assess and manage risks to patients well. They did not always know about any risks for each patient and act to prevent or reduce risks. Patients frequently gained access to items they could harm themselves with. There were many examples of patients harming themselves with things they should not have had access to.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Staff did not complete effective risk assessments for each patient. We looked at risk assessments for five patients on Amy Johnson ward and found that risk ratings were unclear and fluctuated from high, medium and low, but the reason for the change was not recorded. Risk formulation was inconsistent, and some risk assessments lacked detail and did not follow through to care plans.

Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. The provider had a reducing restrictive practice strategy in place, however, the levels of restrictive practices on Amy Johnson ward were high. For example, several patients told us, and some staff confirmed this, that as part of the membership rules for the ward all patients had to attend four meetings a day called 'check in/check out'. The first meeting started at half past seven each morning and ran Monday to Friday. Patients had to attend even if they did not want to, as staff insisted patients attended. This in turn led to incidents when patients refused to attend. We heard that if patients declined to attend meetings they would not be able to access 'privileges'. On occasions this had led to staff being assaulted and a patient being restrained and placed in seclusion.

Other patients were only given enough clothes for three days at a time. Staff told us that this was because patients were newly admitted, and they needed to monitor potential risks. However, the rationale was not recorded in care records, and there were no recorded targets or discussions with the patients as to when they would have access to the rest of their clothes.

Staff told us that they believed that such practices were not restrictive for patients as they were part of the ward/ membership rules. Senior staff told us that restrictive practices between wards were inconsistent and many staff approached this in a different way. They had noted this as an area for improvement.

We reviewed minutes from reducing restrictive practice meetings between December 2020 to March 2021 and found that whilst restrictive practices meetings were taking place on the ward, concerns identified were not followed up with actions, and the monthly clinical audits had not identified this. We also found no evidence that discussions about restrictive practices were embedded in handovers.

Staff access to essential information

Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records. Staff told us they were not always able to access patients' care plans and risk assessments on the electronic system due to frequent problems with the system. Staff that did not regularly work at the hospital did not have log in details, so they could not easily access patient information. This meant that staff may not be aware of patients' individual needs and risks to provide appropriate care to patients.

During the first day of the inspection, we were informed that the electronic system was not working and staff could not access patients' records. Some staff on Amy Johnson ward did not regularly work at the hospital and had no access to patients' care plans and risk assessments. Staff told us that there were no contingency plans in place for when such issues occurred, other than them having access to the ward manager when they needed additional information.

Track record on safety

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately, therefore a true and accurate picture of the risk on the ward was not clear. We found examples where

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

staff had not raised or escalated incidents, because a similar incident had already been previously reported. For example, staff had not recorded an incident in the patient's notes, or discussed at handover, and subsequently the repeated concerns were not escalated. Staff told us they were not aware that the incident needed to be reported as a similar incident had previously been reported and the team were aware of the concerns.

The provider had a review and investigation system for incidents, which required staff to complete reports at 24 hours and 72 hours after an incident. The senior team reviewed incidents and identified those with opportunities for learning to present to a team incident review. Incidents that were progressed to a team incident review were published in a monthly bulletin and circulated to staff and commissioners. However, we were not assured that team incident reviews included all the necessary information, or that learning was always identified. For example, between May 2020 and April 2021, two wards, including Amy Johnson ward, reported between 20 and 149 incidents per month. However, learning was only identified from nine incidents in total per month for the whole hospital.

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

Inspected but not rated

Assessment of needs and planning of care

We reviewed five care plans on Amy Johnson ward and found that they did not always reflect patients' assessed needs and were not personalised and holistic. For example, we found that care plans did not always include information about triggers or bespoke interventions for patients who had a history or current presentation of headbanging. We found that there were patients who had a history of head banging, functional epilepsy and falls, but there was no evidence that staff completed neurological observations following these events. The provider had management of head banging guidance in place, however, staff were not always adhering to it.

One patient's notes indicated that they were experiencing issues around communication, autism and attention deficit hyperactivity disorder, however none of these appeared to be considered in care planning.

Patients did not always have their physical health regularly reviewed during their time on the ward. Physical health observations were not always followed through. We found that staff did not always follow requests from doctors to complete observations in response to incidents. We saw notes for one patient where the doctor had requested enhanced physical observations over several hours, however, these were not completed or recorded. This was in response to an incident where a patient was suspected of swallowing something unknown to staff.

We found that National Early Warning Score (NEWS) charts were not always accurately completed. For example, some scores indicated that escalation of care was needed, but this was not evident in the patients notes and there were no reasons as to why this was deemed to be the case. There was no follow up to check back on the patient's observations. Audits had not been completed which meant that the provider was not aware that some information recorded in these charts did not correlate with other patient records, or care and treatment given.

Staff did not regularly review and update care plans when patients' needs changed. Information on care records, paper and electronic, did not always match. For example, patients had a folder which included information about key risks

and items patients could not have access to. We found that often this information contradicted with the information kept in the patients' electronic records. For example, a patient's paper records stated that the patient should not have access to laptops or phones and no reason was recorded. However, the patient's electronic records stated that the patient could have access to a laptop and phone, if they were supervised, and the reason included.

Best practice in treatment and care

Staff did not always use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The use of such scales was inconsistent and sporadic, and they were not reviewed by the multidisciplinary team. Where these had been completed, staff did not reference them in the patients' daily notes or handover notes.

Staff did not always meet patients' dietary needs. Food and fluid intake and targets for some patients was meant to be recorded on nutrition charts due to eating disorders, such as restricting food. However, staff were not always completing these. When completed, they lacked detail, information recorded was inaccurate and they were not recorded in the patients' daily notes. Staff did not always discuss patient's nutrition or hydration needs at handover and these were not always reviewed as part of ongoing multidisciplinary meetings. This meant that staff may not be aware of patients' individual needs and risks associated with nutrition and hydration and it would be difficult to know when to escalate concerns because information was not being recorded appropriately. The service had access to support from an external dietician, who visited the ward once every two weeks to meet with the patients. However, plans developed by the dietician for the patients were not always followed by staff.

However, staff ensured that patients had access to psychological therapies such as dialectical behavioural therapy and cognitive behavioural therapy. Interventions were based on individual needs and assessment and delivered in group sessions and on a one-to-one basis with the patient.

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

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. The hospital had recently recruited a new hospital director who had identified some main areas of improvement at the hospital and was putting together an action plan, which included actions taken to immediately address challenges with staffing.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that risk was not managed well. For example, clinical governance meetings minutes often lacked actions, analysis or follow ups on actions being done. Actions from lessons learnt were not always followed through and shared with the team. We could not find any minutes from staff team meetings on Amy Johnson ward.

Multidisciplinary team meetings did not thoroughly and effectively discuss patient safety and risk management. Risks and patients' needs were not discussed holistically with input from all members of the multidisciplinary team.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

There was no evidence of change and follow up when patients raised concerns during community meetings. For example, patients raised concerns about not having enough skilled staff and the minutes we reviewed did not have progress recorded against actions that needed to be followed up.

Managing of risks, issues and performance

Staff did not always have access to the information they needed to provide safe and effective care and did not always use that information to good effect. Staff told us that the hospital's electronic systems were generally poor and slow and sometimes they had to come to work very early to complete tasks.

Although the service had a risk register in place, it did not always include information about reviewing actions and who was checking to see whether risks had been mitigated.

This section is primarily information for the provider

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **The provider did not ensure that all staff were always able to access and follow patients' care plans and risk assessments, in order to provide care and treatment to patients in a safe way.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure that there were effective governance processes in place to support good quality of care delivery, and did not ensure there was clear oversight of care by leaders of the hospital, so action could have been taken quickly to make improvements.**