Affinity Healthcare Limited

The Priory Hospital Middleton St George

Inspection report

Middleton St George Hospital
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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	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Priory Hospital Middleton St George is a 104-bed hospital that provides 24-hour support 7 days a week for people aged 18 years and over with mental health problems, personality disorders or both.

Our rating of this service went down. We rated it as requires improvement because:

- We inspected both of the location's two core services: the long stay and rehabilitation wards and acute wards and psychiatric intensive care units.
- We rated the acute wards and psychiatric intensive care units requires improvement under the Safe and Well Led key questions and the service as requires improvement overall. We rated the long stay and rehabilitation wards as good under each key question and the service good overall.
- When the ratings were aggregated, the overall rating for the location is requires improvement.

We rated The Priory Hospital Middleton St George as requires improvement because:

- During our inspection visits, system, and resources to enable the provider to monitor the cleanliness and safety of some wards were not fully effective. We found the service was not clean or well maintained in some areas.
- We had identified, during our Mental Health Act review in September 2023, that fully effective operating systems, to ensure seclusion processes within the service were in line with the Mental Health Act Code of Practice, were not place. This was because medical reviews had been carried out by advanced practitioner nurses and not responsible clinicians or duty doctors as stated in the Code of Practice. Following internal staff discussions, the provider had agreed they would cease this practice and had plans in place for how this change would be implemented.
- Nurses did not always complete nursing reviews in line with the requirements of the Mental Health Act Code of Practice. We reviewed 10 seclusion records, pertaining to 7 patients, and founds shortfalls in record keeping that could indicate poor practice, potential risk and that national guidance was not adhered to.
- Some of the nursing staff we spoke with were unable to demonstrate their understanding of the Mental Health Act, Mental Capacity Act and duty of candour.

However:

- The rehabilitation wards provided safe care and 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 ward environments on Linden and Hazelwood were clean and well maintained.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff 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.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason. Staff delivered a recognised model of mental health rehabilitation.

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	Requires Improvement	●	
Long stay or rehabilitation mental health wards for working age adults	Good	●	

Summary of findings

Contents

Summary of this inspection

Page

Background to The Priory Hospital Middleton St George 5

Information about The Priory Hospital Middleton St George 6

Our findings from this inspection

Overview of ratings 8

Our findings by main service 9

Summary of this inspection

Background to The Priory Hospital Middleton St George

The Priory Hospital Middleton St George is a 104-bed hospital that provides 24-hour support 7 days a week for people aged 18 years and over with mental health problems, personality disorders or both.

Patient accommodation comprises of:

- Birch ward – psychiatric intensive care unit for men (10 beds)
- Chester ward – psychiatric intensive care unit for women (10 beds)
- Oak ward – acute admission ward for women (12 beds)
- Sycamore ward – acute admission ward for women (15 beds)
- Thoburn ward – acute admission ward for both women and men (22 beds)
- Dalton ward –Longer Term High Dependency Rehabilitation Unit for women (13 beds)
- Hazelwood ward – Highly Specialist Inpatient Rehabilitation Unit for women (10 beds)
- Linden ward – Longer Term High Dependency Rehabilitation Unit for men (12 beds).

The hospital director is the registered manager and has been in post since February 2020. The hospital is registered with the Care Quality Commission to provide the following regulated activities:

- assessment or medical treatment for people detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

There have been 13 inspections carried out at the Priory Hospital Middleton St George in the previous 11 years.

The most recent inspection was in May 2021, following which, the hospital was rated good overall and under each of the key questions we ask.

We undertook a Mental Health Act monitoring visit of Birch and Chester wards in September 2023. We found the following issues:

- patients currently in seclusion did not have seclusion care plans in place and advanced practitioner nurses were carrying out seclusion reviews that were meant to be done by a qualified doctor.
- there were blanket restrictions in place which were disproportionate to the risk identified.

What people who use the service say

We spoke with 25 patients using the service and 3 carers. This included 13 patients on the rehabilitation wards and 12 on the acute and PICU wards. Most patients told us staff treated them in a kind, caring and respectful way. Two patients on Sycamore ward did not always feel listened to and told us some staff did not always respond to them appropriately.

Patients and carers told us they were involved in decisions about care and treatment and were able to give feedback about the service. They knew how to complain and were aware of advocacy services that could support them and speak on their behalf. Patients said there was always someone they recognised and felt able to speak with.

Patients said they felt safe, and they were supported to keep in touch with family and the local community. They used the site shuttle bus and staff supported them to spend time away from the service.

Summary of this inspection

Patients said they were a long way from home. Patients understood the restrictions and why these were in place and said they had access to advocates and could raise concerns through regular community meetings.

How we carried out this inspection

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

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

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

- visited all 8 wards within the hospital.
- spoke with the director of clinical services.
- spoke with the associate director of clinical services who was covering for the absence of the ward manager on Sycamore ward.
- spoke with 25 patients who were using the service and 3 carers.
- spoke with 7 ward managers.
- spoke with 39 staff members including nurses, occupational therapists, Mental Health Act administrators and healthcare assistants.
- checked the quality, safety and cleanliness of the environment of the wards and,
- reviewed the medicines management arrangements, including a check of the clinic rooms.
- reviewed 1 seclusion record onsite and another 9 remotely due to experiencing connectivity issues at the hospital.

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 service 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.

Action the service MUST take to improve:

- The provider must ensure that all wards are clean and well-maintained, by adequate numbers of housekeeping and maintenance staff to ensure the safety and wellbeing of all patients and to promote a therapeutic environment. This includes but is not limited to ensuring that all patients have continual access to hot water and adherence to infection control and safety protocols.

15 (1) (a) (c) (e)

- The provider must ensure that improvements are made to the lighting and safety in relation to the exterior areas at nighttime to ensure staff, patients and visitors are safe in the hospital grounds.

15 (1) (b) (c)

- The provider must ensure there are effective systems in place to ensure that all seclusion records are completed in line with the requirements of the Mental Health Act Code of Practice. The provider must ensure that all seclusion episodes are reported as incidents in line with their own policy and to ensure oversight and monitoring.

17 (1) (2) (a) (b) (c)

- The provider must have in place effective systems to enable them to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). This includes but is not limited to improvements to internet access for patients and staff.

17(1) (2) (a)

Action the service SHOULD take to improve:

- The provider should operate effective systems to ensure all staff on the wards have good, up-to-date knowledge of the Mental Health Act, Mental Capacity Act and the duty of candour.

- The provider should consider ways to improve relationships between the hospital’s senior management team and staff on Thoburn ward to ensure staff on the ward feel valued, respected and listened to.

- The provider should operate effective signing in and out of the service to ensure the current location of all people on site is correct and any emergency evacuations are carried out safely.

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	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

Not all the wards were clean, well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

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

Staff could observe patients in all parts of the wards. Blind spots were mitigated by the combined use of mirrors, patient observations and closed-circuit television.

The ward complied with guidance around mixed sex accommodation. Thoburn ward was a mixed sex ward, male and female bedrooms were located on separate corridors, and there was a female lounge on the first floor.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe through the use of patient observations and restrictions to rooms.

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

The first day of our inspection was undertaken on the evening of 11 December 2023. We arrived at 6pm and found the car park and surrounding areas were not sufficiently lit. A staff member on shift told us they were nearly knocked over by a vehicle due to the driver being unable to see them. However, we attended a patient safety review meeting the next day and noted plans were already in place to increase the use of high visibility jackets and add better lighting outside.

There was an inconsistent approach to the requirement to sign in and out of the wards. Sometimes members of the inspection team were asked to sign their name, and which ward they were visiting and at other times this did not happen. This could have potentially caused issues if there was an emergency evacuation as fire wardens would not have access to the correct whereabouts of people onsite.

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

Requires Improvement

Maintenance, cleanliness and infection control
During our inspection visits, system and resources to enable the provider to monitor the cleanliness and safety of some wards were not fully effective. We found the service was not clean or well maintained in some areas.

The seclusion room on Birch ward and the enhanced care suite room had been temporarily decommissioned due to extensive damage caused by a patient.

On Birch ward, 2 rooms were in a poor state of repair. The provider told us that the room was used as a flex room and due to the state of disrepair had been taken offline as a useable room until the necessary repairs had been completed. Flex rooms were spare rooms made available in case any other rooms needed to be repaired.

In the other room, a desk and other surfaces had flaking paint on them. There was debris and grit on the floor and sealant around the edges of the flooring looked dirty. The provider advised that debris on the floor was due to the patient walking in and out of the garden.

On Thoburn ward, bedrooms were in poor state of repair. For example, paint was chipped, and holes on showers were covered with grout. We found heavy brown staining on the floor, toilets and walls in 1 room. Toilets were badly stained in patient bedrooms. Radiators on the ward were rusty and dusty. Plaster was chipped and peeling from walls. Some patients did not have access to hot water.

After our site visits the provider told us that Thoburn, which is a large ward environment, required significant work to be undertaken and agreed that some bedrooms required refurbishment. They planned to undertake this work in a safe and coordinated manner to avoid risk and disruption to patients' care.

Staff did not always ensure cleaning records were up to date. There were a significant number of gaps in cleaning records on Birch ward. Seclusion rooms were not included within cleaning rotas. The provider told us this would be rectified. The number of cleaning staff had been reduced from 12 to 6 and this was having a detrimental impact on the cleanliness of the wards.

Seclusion room
There were seclusion rooms on Chester and Birch wards. The seclusion rooms allowed clear observation and two-way communication. Both rooms had toilets and clocks. However, the clock on Chester ward had an incorrect time and date. The phone signal on Birch ward was not working which meant there were issues for the patient occupying the room if they wanted to speak with their loved ones.

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

Safe staffing
The service had enough nursing and medical staff to ensure safe staffing levels. This included regular bank and some agency staff with occasional nurse shortages at night were covered by managers as part of their clinical input. Staff knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

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

Requires Improvement

The service used regular bank staff to ensure that they had enough nursing staff. The use of agency staff had reduced over the previous 6 months. There were occasions when ward and senior managers stepped in to fill occasional nights when there was no nurse cover due to last minute sickness.

We reviewed a sample of staffing rotas and saw 6-night shifts in November 2023 when this had happened. The provider sent us evidence after the inspection that on the shifts in question, there had been support from a night manager and some shifts were covered by agency staff.

Although ward managers worked during the day, they had some clinical time built into their role so they could support wards if required or use this time to have oversight of both day and night shifts.

The service had reducing vacancy rates with 5 qualified nurses and 24 healthcare assistants due to start working in January and February 2024.

At the time of the inspection the vacancy rate was 13.7% for qualified and 14% healthcare assistants which equated to 20.15 whole time equivalent healthcare assistant and 6.51 whole time equivalent nurse vacancies.

In the 12 months prior to the inspection, 2,632 shifts were covered by agency staff. Data showed that agency use had reduced since July 2023 with 660 shifts in the previous 6 months compared with 1,972 between January 2023 and June 2023. Most of these shifts related to patients being on enhanced observations, requiring more than 1 member of staff to carry out patients' observations safely.

We spoke with permanent staff who told us that wherever possible, managers arranged for regular bank and agency staff to cover shifts, so they were known to the patients and knew how the service operated.

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

The service had low turnover rates. The average turnover in the last 12 months was 2%.

Managers supported staff who needed time off for ill health.

Levels of sickness were low. The average sickness absence within the service was 2%.

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

The ward manager could adjust staffing levels according to the needs of the patients.

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. Only 1 community leave, and 9 activities were cancelled in the previous 12 months; none of which were due to staffing issues.

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.

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

Requires Improvement

Medical staff

The service had enough day and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. There were onsite doctors and nurses during the day, on-call doctors at night and the service is approximately 20 minutes' drive away from the local acute hospital.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At the time of our inspection, the overall compliance with mandatory training was 86% which was slightly below the provider target of 90%. Courses that fell below 90% were breakaway training at 88% and safeguarding level 3 at 82%.

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

- basic and immediate life support
- moving and handling
- suicide prevention/self-harm
- health and safety
- safe and therapeutic observations
- safeguarding
- reducing restrictive interventions and,
- safe handling of medicines and diversity and inclusion.

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 and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on or soon after admission using a tool built into the provider's care records system recognised tool. We reviewed 6 records and found that staff reviewed risk assessments regularly, including after any incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce these. Risks included self-harm, suicidal ideation and violence and aggression.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in all parts of the wards. Blind spots were mitigated using mirrors and closed-circuit television.

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

There were 1,240 incidences of restraint within the service in the previous 12 months, 3 of which were in the prone position. The highest outliers were Chester ward (809) and Sycamore ward (211), both of which were female wards with high levels of attempted self-harm and suicidal ideation.

Staff participated in the provider's restrictive interventions reduction programme. Most staff had received training in the provider's reducing restrictive practice programme [CH2] which incorporated the Use of Force Act with compliance at 88%. All wards were issued with use of force posters and guidance for staff and patients to access.

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. De-escalation techniques included verbal de-escalation, redirection or arranging for a member of staff the patient was familiar with to talk with them.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Blanket restrictions within the service were appropriate to the patient group and were reviewed monthly. For example, on the psychiatric intensive care units, due to the risk of self-harm and suicidal ideation within the patient groups, there was restricted access to rooms with ligature points such as the communal bathroom, kitchen and laundry. However, on Birch ward the hot water facility was out of use due to pending works to install temperature controls. This meant patients temporarily needed to seek support from staff to access hot drinks.

The use of vapes on the wards was dealt with on an individualised basis, in line with the patient's care plan and as a form of nicotine replacement therapy.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. There were 520 incidences of rapid tranquilisation within the previous 12 months. The highest outliers were Chester ward (392) and Sycamore ward (79).

There were 48 incidents of seclusion within the previous 12 months. The highest outliers were Chester ward (19) and Birch (27).

When a patient was placed in seclusion, staff did not keep clear records or follow best practice guidelines. We reviewed 10 seclusion records pertaining to 7 patients within the service, all of which contained evidence of poor practice and non-compliance with the Mental Health Act Code of Practice. This included:

- In 9 out of 10 records, nurse reviews were not being carried out by 2 nurses every 2 hours as required under the Mental Health Act Code of Practice.
- In 9 out of 10 records, advanced practitioner nurses carried out medical reviews which was not in line with the Mental Health Act Code of Practice.
- In 5 out of 10 records, medical reviews were not being carried out every 4 hours as required under the Mental Health Act Code of Practice.
- In 2 out of 10 records, the patient's noted presentation indicated that they were not taken out of seclusion at the earliest opportunity. In 1 record, it was continually documented that the patient was settled and not agitated and in the second record, nurse reviews consistently stated there were no concerns, but the seclusion was delayed due to an advanced practitioner nurse waiting to consult a doctor about ending the seclusion.
- In 3 out of 10 records, the names of nurses carrying out the reviews were not recorded.
- In 2 out of 10 records, the designated roles of staff undertaking seclusion reviews were not recorded.

- In 2 out of 10 records, there was no evidence that any family members or advocates had been informed about the patient being placed in seclusion.
- In 5 out of 10 records, there was no evidence independent multidisciplinary team reviews were carried out as required.
- In 3 out of 10 records, the reasons for ending or continuing seclusion were not recorded.
- In 2 out of 10 records, there was no evidence of a seclusion care plan being in place for the patient.
- In 4 out of 10 records, there was no evidence of the seclusion being reported as an incident.
- In 5 out of 10 records, staff had not recorded what items the patient took into the seclusion room with them.
- In 1 out of 10 records, staff had not recorded the name of the ward for which seclusion room was used.
- In 4 out of 10 records, there were discrepancies in relation to the time the episode of seclusion commenced.

The issue around advanced practitioner nurses carrying out medical reviews had been identified following our Mental Health Act monitoring visit in September 2023. The provider told us following that visit they were working with the head of mental health to ensure compliance with the Code of Practice.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. In the previous 12 months, there were 21 incidences of long-term segregation within the service. The provider referred to this as enhanced care suites in which patients with high acuity whose needs could not be safely met were nursed away from the wards.

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 kept up to date with their safeguarding training. At the time of our inspection, 93% of staff had completed safeguarding Level 1 training with 82% of staff completing safeguarding Level 3 face to face training.

Staff could give examples of how to protect patients 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 followed clear procedures to keep children visiting the service safe. These visits were pre-arranged and took place in a room away from the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There were 6 safeguarding leads, and 9 deputy leads within the service so staff always had access to somebody who could provide advice and guidance if they had any concerns about patient safety and welfare.

There was one serious case review within the service within the previous 12 months which related to a patient death in June 2023 which the provider notified us about via a statutory notification. The death had been the subject of a coroner's inquest and led to a prevention of future deaths report being issued to the provider.

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

Requires Improvement

Staff access to essential information

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

Other than the issues with completion of seclusion documentation, patient notes were comprehensive, and all staff could access them easily most of the time.

The internet connectivity within the hospital could be slow and sometimes led to staff experiencing problems when accessing the provider's electronic care records system.

Although the service used a combination of electronic and paper records, staff made sure they were up to date and complete.

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 prescribe, administer and record medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. We reviewed 18 patients' prescription charts and saw they were completed clearly and correctly.

Staff stored and managed prescribing documents and medicines safely.

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

Staff learned from safety alerts and incidents to improve practice. The provider had issued learning bulletins to staff. These included the need to be aware of items patients had ordered via online pharmacy services as they could contain banned or restricted items which could be detrimental to their health.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Patients had regular physical health monitoring in accordance with their Keeping Healthy care plan, including physical health observations (using the National Early Warning Score 2 tool) and routine blood tests, to establish their baseline presentation. Subsequent monitoring adhered to national guidance, including the National Institute for Health and Care Excellence and Maudsley prescribing guidance. The provider's 'Monitoring Physical Health of Inpatients Policy' outlined recommended monitoring for new inpatients, which included physical observations, weight and height, an electrocardiogram and various blood tests. Staff completed these within 72 hours of admission subject to patient consent. The hospital also had a service level agreement with a local primary healthcare service which provided a weekly GP clinic to contribute towards physical healthcare management on site.

We saw evidence in patient care records that staff reviewed the effects of each patient's medicines on their physical health according to the National Institute for Health and Care Excellence guidance.

Track record on safety

There had been 2 serious incidents within the service in the previous 12 months, both of which happened when the patients were away from the wards. These were both deaths, 1 relating to a patient on Thoburn ward and another to a former patient on Oak ward.

The Thoburn incident was whilst on home leave and the Oak patient had been discharged following a Mental Health Act tribunal. The provider had learned lessons from the death of the patient on Thoburn ward. This included better involvement with others in planning overnight leave, risk assessing and providing contact information and arrangements for return to the ward.

Reporting incidents and learning from when things go wrong.

The service did not always manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately. The seclusion records we looked at during our inspection indicated staff had not recorded the use of seclusion as an incident.

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.

The main incidents within the service were self-harm, suicidal ideation and violence and aggression.

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

Not all staff understood the duty of candour with 5 out of 21 nursing staff unclear what the duty of candour was. The registered manager informed us that additional training around the duty of candour was to be given in response to our findings[CH4] .

Managers debriefed and supported staff after any serious incident.

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

Staff received feedback from investigation of incidents, both internal and external to the service during team meetings, supervision and by email.

There was evidence that changes had been made as a result of feedback. Following incidents, closed circuit television and windows with toughened glass had been installed on Thoburn ward. On Birch ward, staff had been reminded to always close the door to the nurses' office as there had been occasions where patients had been able to enter the room.

There had been no 'never events' within the service in the previous 12 months. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

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

Requires Improvement

Is the service effective?

Good

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

Assessment of needs and planning of care

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

We reviewed 6 patients' care records during our inspection.

We saw evidence that staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

We saw evidence that staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery orientated.

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. These included occupational therapy assessments, coping strategies and techniques, psychology and therapeutic activities.

Staff delivered care in line with best practice and national guidance in most areas. However, staff had not been adhering to the Mental Health Act Code of Practice in relation to medical and nurse reviews for patients in seclusion. This had been picked up during a mental health act visit and the provider had started to put measures in place at the time of the inspection.

Staff identified patients' physical health needs and recorded them in their care plans. Staff used the National Early Warning Scale 2, Lunsers, electrocardiograms, blood monitoring, venous thromboembolism monitoring and weight monitoring to assess and monitor patients' physical health.

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

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. Staff encouraged patients to take regular exercise, make healthy meal choices and provided nicotine replacement therapy to reduce health risks associated with smoking.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the Health of the Nation Outcome Scores and National Early Warning Scotes tools.

Staff used technology to support patients. Patients had access to Wi-Fi and mobile phones so they could keep in touch with people who mattered to them. However, the internet connectivity at the hospital was very slow at times.

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

- audits of consent to treatment forms on Birch and Chester wards
- a supervision audit on Birch ward
- a healthcare audit including checks of ligatures, fire safety, safeguarding, the use of the Mental Health Act and Mental Capacity Act, and infection control and
- a standalone separate Mental Health Act audit.

However, there was no recorded evidence to show that that monthly manager audits had been completed on Birch ward for September and October 2023. The audits had not identified the issues with seclusion records.

Managers used results from audits to make improvements. For example, the supervision audit on Birch ward identified a need to separate supervision files by permanent, bank and agency staff. Also, to continue with improvement of records within the provider's supervision system and to add regular bank workers to the main supervision recording log.

Skilled staff to deliver care

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

The service included or had access to a full range of specialists to meet the needs of the patients on the ward. These included psychiatrists, psychologists, nurses, occupational therapists, healthcare assistants, nurses from a GP practice, speech and language therapists and chiropodists.

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.

Managers supported permanent staff to develop through yearly, constructive appraisals of their work. The compliance rate at the time of our inspection was 92% within the service.

Managers supported staff through regular, constructive clinical supervision of their work. The average compliance with supervision at the time of our inspection was 84%.

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

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

Managers made sure staff received any specialist training for their role. Staff had undertaken courses in venepuncture, electrocardiograms, physical health, controlled drugs and first aid.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider had a performance management procedure which included guidance on how to deal with poor performance in an appropriate and timely manner.

Multi-disciplinary and interagency teamwork

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

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

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed handovers on the wards, and they were clear, comprehensive and well documented.

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

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

Not all of the staff within the service understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.

Staff understanding varied across the service with 7 out of 21 nursing staff unable to demonstrate they had a good understanding of the Mental Health Act. Following the inspection, the provider shared their plans to roll out further training in the Mental Health Act to improve staff knowledge across the wards. Current compliance of training was above the provider target with [CH2] Mental Health Act 93% and the Mental Health Act Code of Practice 95%,

Staff had been failing to comply with the Mental Health Act Code of Practice in relation to medical and nurse reviews for patients in seclusion. The provider had already taken action to address this and had training planned for their medical and nursing staff.

Staff had access to support and advice on implementing the Mental Health Act and the Mental Health Act Code of Practice from an onsite Mental Health Act administration team. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The Mental Health Act administrators checked admission papers, ensured patients admitted to the service were given their rights under the Act and were made aware of advocacy services and the Care Quality Commission.

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.

We saw evidence in care records that 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.

We saw evidence in patient care records that 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. Patients told us they had access to section 17 leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

Managers completed audits which were designed to ensure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

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

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

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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

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

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 via monthly audits carried out by ward managers.

Is the service caring?

Good

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

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

Requires Improvement

Kindness, privacy, dignity, respect, compassion and support

Most 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.

Most staff were discreet, respectful, and responsive when caring for patients. We undertook detailed observations on Thoburn ward as part of 'our observing, understanding, and influencing cultures' framework. We noticed staff had a good rapport with patients. They chatted about hobbies and interests and were kind, caring and respectful towards the patients on the ward. During our inspection, we observed staff being kind, considerate and helpful to patients on the other wards within the service. We spoke with 12 patients using the service, 10 of which told us staff treated them well and were supportive. Two patients on Sycamore ward did not always feel listened to and told us some staff did not always respond to them appropriately.

Staff gave patients help, emotional support and advice when they needed it.

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

We saw evidence in care records that 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 felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

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.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service, when appropriate and were able to give feedback on the service they received. Patients could complete feedback forms and surveys and there were community meetings on the wards during which, patients could share their ideas for improving the service.

Patient representatives attended patient safety meetings, clinical governance meetings each month and patient forums. Patients were also involved in the recruitment of healthcare assistants and senior staff and facilitated a session during the induction programme for new staff.

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

Requires Improvement

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with 3 carers of patients who had used or were still using the service. They told us staff were supportive, kept them informed and involved them in their loved one's care and treatment. Two of them said they were given opportunities to provide feedback.

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

Is the service responsive?

Good

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

Access and discharge

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

Bed management

The average bed occupancy within the service in the previous 12 months was 88%.

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

The service had out-of-area placements and routinely took patients from all over England.

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 interests of the patient.

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

Discharge and transfers of care

Most patients did not have to stay in hospital when they were well enough to leave. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. There were 18 delayed discharges in the previous 12 months. The main reason for the delays related to housing issues. One delayed discharge related to a patient who was waiting for a bespoke placement.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

We saw evidence in care records that 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 hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access easily. In September 2023, a Mental Health Act monitoring visit identified that the outside space was sparse and uninviting. During this inspection, we noticed some improvement in the quality of the outside space as the provider had procured additional furnishings to create a more therapeutic environment. However, we found the outside seating area on Birch ward was dirty and unpleasant in its appearance.

Most patients could make their own hot drinks and snacks and were not dependent on staff. On Birch ward, patients had to ask for hot drinks as the ward was waiting for a water temperature gauge to be fitted to ensure the water was of a safe temperature to avoid scalding.

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 they supported patients. Patients accessed courses at a recovery college, an onsite library and occupational therapists provided support and materials to improve their education and job prospects.

Staff helped patients to stay in contact with families and carers. Patients could contact families and loved ones by using social media platforms, telephone and where possible, onsite visits.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

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

The service had the facility to produce information leaflets which were available in languages and formats used by the patients and local community.

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients. We were told during our Mental Health Act monitoring visit in September 2023 that halal food options were limited, and a patient told us they had requested to see an Imam, but this had not happened. However, during this inspection, we noted there were now a good range of halal food options available to patients following the Islamic faith that were obtained from an outside catering service. Wards also had a list of local Imams and made efforts to arrange for an Imam to attend the ward when needed, subject to their availability.

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 were 35 complaints within the service in the previous 12 months of which 1 was upheld and 15 partially upheld.

Staff protected patients who raised concerns or complaints from discrimination and harassment. All complaints were dealt with in a confidential manner. If a complaint related to a member of staff, the staff member was moved to another ward whilst the investigation was ongoing to protect both the patient and the staff member concerned.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, following a complaint around lost property, a recommendation was made to improve the process for documenting patients' property on arrival and during admission.

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

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

Requires Improvement

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed.

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

Leaders had a good understanding of the services they managed. They were aware of issues in relation to the quality of the care environment on Thoburn ward but had yet to address them. After our site visits, they provided assurances and detail of their plans to improve and upgrade the premises on this ward.

Most staff within the service told us leaders were visible and approachable for patients and staff.

However, the staff we spoke with on Thoburn ward said they rarely saw members of the senior management team unless something had gone wrong.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

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

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff could raise their suggestions for how to improve the service at team meetings or during supervision sessions.

Culture

Not all staff we spoke with felt respected, supported and valued. The provider promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could raise any concerns without fear.

Not all staff we spoke with felt respected, supported, valued, positive or proud about working for the provider and within their team. Staff on Thoburn ward did not feel respected, appreciated or valued by managers above ward manager level. Managers were aware of the disconnection with themselves and staff on the ward. Following our inspection, the provider shared details of how they intended to improve relationships. This included fortnightly, full team meetings with the senior management team, listening events, access to Quality Improvement training and improved morning meetings.

Mental Health Act administrators had told the senior management team they were struggling with their workloads and were working a significant number of hours overtime as a result.

Managers dealt with poor staff performance when needed.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. There were equality and diversity policies in place, all staff were required to complete equality and diversity training and there were multi-faith rooms within the hospital. There were specific diversity and inclusion networks in the organisation, including for LGBT+, disable people, menopause, neurodivergent people, people who had served in the armed forces, women, men and people from ethnic minority groups.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers kept in regular contact with staff on long-term sickness absence. There was an employee assistance programme which included access to a counselling service and the provider's website included health and wellbeing advice. Staff had access to a self-help app to promote a healthy mind and overall wellbeing and bereavement support.

The provider recognised staff success within the service via staff awards and 'thank you' letters and emails.

Governance

Our findings in relation to the quality of the environment and the use of seclusion within the service demonstrated that governance processes did not always operate effectively at team level and placed patients at potential risk of harm.

Some of the provider's governance systems were ineffective in ensuring patients received safe care and treatment and the hospital ran well. The delivery of high-quality care was not always assured by the leadership and governance within the service.

The lack of an effective system being in place to monitor the cleanliness and safety of some of the wards meant the provider had failed to mitigate the risks associated with infection prevention and control. Also, the need to maintain accommodation which provided a therapeutic environment and avoided any risks to patients.

The provider had not been operating effective systems to ensure that seclusion processes within the service were in line with the Mental Health Act Code of Practice. This may have impacted on their ability to identify, assess and mitigate risks to patients within their care. Senior leaders were now fully aware that the use of advanced practitioners to undertake medical reviews was not in line with the Code of Practice and were following their plan of action to address this.

10 seclusion records pertaining to 7 patients contained evidence of poor practice and that national guidance was not being adhered to. These included nurses and medical reviews not being carried out in line with the Mental Health Act Code of Practice, and shortfalls in the recording of decisions about starting and ending seclusion, the reporting of seclusion as an incident and the inclusion of names and roles of staff carrying out seclusion reviews.

Senior leaders had not ensured that staff had adequate knowledge of the Mental Health and Mental Capacity Acts or the duty of candour.

Staff vacancies were high within the service. However, new staff were due to start working within the service over the 2 months following the inspection which would significantly reduce these vacancies.

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

Staff understood the arrangements for working with other teams, both within the provider group 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.

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

Staff concerns matched those on the risk register.

The service had a business continuity plan for dealing with emergencies such as adverse weather, fire or bomb scares or a flu outbreak.

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 wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment needed to do their work. The telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies such as the local authority, commissioning teams and the Care Quality Commission when required.

Engagement

Managers engaged actively with 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 through the intranet, bulletins, emails and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs and were involved in decision-making about changes to the service.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

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

Leaders engaged with external stakeholders. Members of the senior management team met with commissioners from the North East and North Cumbria Integrated Care Board on a quarterly basis or more frequently if required to discuss all key performance indicators they had set and any anomalies around trends, lessons learned and safeguarding.

The ward teams and admission manager held weekly meetings with West Yorkshire bed managers as the service had contracted beds on Birch, Thoburn and Oak wards.

The hospital director had recently been working alongside the North East and North Cumbria evolving group and North East and North Cumbria Integrated Care Board. This involved coming together as a collective group to look at quality standards for inpatients and strengthening the oversight and support arrangements for inpatient mental health services.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.

Staff used quality improvement methods and knew how to apply them. These included quality walkarounds and assurance visits undertaken by members of the senior management and the reducing restraint and interventions teams.

Long stay or rehabilitation mental health wards for working age adults

Good

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

Is the service safe?

Good

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

Safe and clean care environments

Most wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Lindon and Hazelwood had been recently refurbished but maintenance work was outstanding on Dalton ward.

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 knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligatures points were contained within ward ligature maps which highlighted the risk areas. Blind spots were managed through a combination of observations and risk assessments and the positioning of mirrors or vision globes.

The ward complied with guidance and there was no mixed sex accommodation.

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

The first day of our inspection was undertaken on the evening of 11 December 2023. We arrived at 6pm and found the car park and surrounding areas were not sufficiently lit. A staff member on shift told us they were nearly knocked over by a vehicle due to the driver being unable to see them. However, we attended a patient safety review meeting the next day and noted plans were already in place to increase the use of high visibility jackets and add better lighting outside.

Maintenance, cleanliness and infection control

Long stay or rehabilitation mental health wards for working age adults

Good

Most ward areas were clean, well maintained, well-furnished and fit for purpose. Linden ward had recently been renovated and Hazelwood ward was partially refurbished with half of the rooms complete. Dalton ward needed some maintenance work which managers had escalated for completion. Some areas needed attention and were cluttered and untidy on the day of the inspection.

Staff made sure cleaning records were up-to-date and the premises were clean. The number of cleaning staff had been reduced from 12 to 6 and this was having a detrimental impact on the hospital with staff having responsibility for some cleaning tasks.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment.

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. There was always a qualified member of staff on each shift. Data showed that support staff did sometimes have to be moved to meet the needs of the service. We observed this on the evening of the first day of the inspection. Staff were moved wards due to last minute sickness or the need to have more female staff on the wards. Qualified staff managed this process and told us that staff were contracted to work at across the hospital rather than a specific ward. Mangers were sometimes required to make up the numbers on wards and some worked as part of the bank.

The service had reducing vacancy rates at 4% for qualified and 8% for support workers which equated to 1 Nurse vacancy and 4 support worker vacancies.

The wards had a mix of experienced staff and staff who were new to the hospital. Staff were being supported to become familiar with the wards and patients.

The service was using regular bank staff to cover shifts and agency use had reduced over the previous 6 months. The data showed that 459 shifts had been covered by agency staff in the previous 12 months but that 410 of these were before July 2023. This meant that shifts covered by agency had reduced to 49 in the previous 6 months. For nightshifts 240 out of 315 shifts were before July 2023. We saw that 9 shifts had not been covered and the wards were below staffing numbers for qualified staff on these occasions. Reasons included last minute sickness or cancellation of agency staff. Additional support staff had been used to support shifts with nurses working across both wards. On all occasions a nurse on call or the nurse who was already on duty supported with medicines management.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers used bank staff where possible by using a 'text burst' system. They tried to limit the use of agency staff which was not always possible if shifts needed to be filled quickly. Some agency staff were familiar with the service but preferred to be agency rather than permanent staff.

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

The service had a low turnover rate which was currently at 2%.

Managers supported staff who needed time off for ill health.

Levels of sickness were currently 5.89%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The hospital used a staffing ladder and could adjust staffing levels according to the needs of the patients.

Patients had regular one- to-one sessions with their named nurse. Patients said they knew who their named nurse was and were able to see them regularly. The record we reviewed supported this.

Patients rarely had their escorted leave or activities cancelled, and there had been 11 reported periods of cancelled leave in the previous 12 months. Reasons included lack of motivation of patients and illness of either patients or on one occasion staff.

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. We observed handover meetings taking place and staff sharing information to staff who arrived on the ward.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. Linden and Dalton wards each had their own full-time psychiatrist. At the time of the inspection, Hazelwood ward was supported by two psychiatrists. Each responsible for half of the caseload. Together these psychiatrists supervised a multi-professional approved clinician in training, working on the ward.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. At the time of our inspection, the overall compliance with mandatory training was 86% which was slightly below the provider target of 90%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training included, basic and immediate life support, moving and handling, suicide prevention/self-harm, health and safety, safe and therapeutic observations, safeguarding, reducing restrictive interventions, safe handling of medicines and diversity and inclusion.

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. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a standardised template which followed the principles of nationally recognised tools within mental health They reviewed this regularly, including after any incident. Individual risk was reviewed daily, and the care records system was updated accordingly. We reviewed 9 care records during our inspection and found risk assessments to be clear and well detailed. We saw evidence of patient and multidisciplinary team involvement in initial formulation and reviews of risk assessments.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff could describe how risks could change depending on the persons presentation.

Staff identified and responded to any changes in risks to, or posed by, patients. They knew the appropriate interventions required to manage risks and these were recorded in care plans. Patients leave was discussed in daily meetings and monitored closely if risks began to increase. Patients were encouraged to access the community and staff took steps to keep patients and the wider community safe. This included making phone calls to patients on leave where appropriate and ensuring contingency plans were in place if anything went wrong.

We saw individual restrictions being put in place such as the removal of patients' mobile phones and other items after incidents. These were regular discussed and documented in care plans.

Some areas, including the nurse's office, treatment rooms and clinic rooms were locked to keep patients safe. All other areas were open, and patients could access these areas freely unless an individual risk was identified. The bathroom on Dalton ward was locked due to ligature risks and this was recorded on a restrictive practice log. The bathroom was still awaiting refurbishment.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. We saw in records this was based on risk assessments,

Long stay or rehabilitation mental health wards for working age adults

Good

Use of restrictive interventions

Levels of restrictive interventions were low on Dalton ward and Linden ward. Between 12 December 2022 and 12 December 2023 there had been 15 incidents of restraint on Linden ward and 42 on Dalton ward. There had been 119 restraints on Hazelwood ward. Most of the restraints on Hazelwood ward were low level and to keep people safe due to self-harm.

Staff participated in the provider's restrictive interventions reduction programme. All staff received training in the provider's reducing restrictive practice programme which incorporated the Use of Force Act. All wards were issued use of force posters and guidance for staff and patients to access.

Staff on Hazelwood ward followed the dialectical behaviour therapy model and used a hand off approach to restraint.

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. Most of the patients we spoke with had no recent experience of restraint. Staff told us restraint was used as a last resort and was usually to prevent self-harming behaviours. Patients told us staff tried to talk to them and supported their understanding of their own trigger points. Staff promoted coping strategies for patients during sessions and groups.

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

Staff followed NICE guidance when using rapid tranquilisation. Rapid tranquillisation had been used 11 times on Dalton ward and 14 times on Hazelwood ward during the previous 12 months.

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 kept up to date with their safeguarding training and compliance for safeguarding level 1 was 85% with safeguarding level 3 face to face training at 82%. Staff could give clear examples of how to protect patients 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 had support from safeguarding leads within the hospital and the local authority. There were 6 safeguarding leads, and 9 deputy leads who staff could contact for advice at any time if they had any concerns about patients' safety and welfare.

Staff followed clear procedures to keep children visiting the ward safe. The social worker lead was developing programmes to support patients who were also parents. This included work to prepare for discharge and going back to a parental role.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been 42 safeguarding referrals across all three wards between December 2022 and December 2023.

Long stay or rehabilitation mental health wards for working age adults

Good

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. However, staff told us the internet connectivity within the hospital could be slow which led to delays in accessing care records.

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

Records were stored securely, and documents were password protected.

Medicines management

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

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

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

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

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.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

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 via the provider's incident reporting system.

Long stay or rehabilitation mental health wards for working age adults

Good

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 patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident during safety huddles. These took place within 2 hours of serious incidents in line with provider policy. The service had recently introduced a safety huddle template which prompted managers to ensure team discussions took place and that immediate actions were documented.

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. Managers circulated lessons learnt bulletins and we saw examples of discussions around the disguising of harmful objects and for staff to ensure that they were meeting observation and engagement documentation standards.

Staff met to discuss the feedback and look at improvements to patient care. There had been several bulletins highlighting risks for staff to be mindful of. These included items available to easily buy online or of patients hiding harmful object in everyday items, jewellery with hidden blades, pens with blades and vapes with razors hidden inside. Small magnets had also been found inside socks. Staff were advised to be vigilant to patients' online activity and when checking incoming post and packages. We observed staff checking patients shopping purchases on Dalton ward and cross referencing these against risk assessments.

Staff were also reminded that the quality of observation and engagement must meet the standards required.

Is the service effective?

Good

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

Assessment of needs and planning of care

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

We reviewed 9 sets of care records and saw that staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Patients had access to a GP on-site and advanced practitioners to support physical health care. A physical health nurse worked across the site supported staff and patients. Staff on Hazelwood and Dalton wards had delivered several well women health promotion talks which included breast self-examination, diabetes, pap smear (a tool for the diagnosis of cervical cancer), and cancer awareness.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed and we found that care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. Treatment was in line with best practice and national guidance and included dialectical behaviour therapy (DBT), cognitive behavioural therapy (CBT), and psychology input. Hazelwood ward was a specialised personality disorder ward for women and followed the DBT programme. Patients told us they had psychology sessions and one-to-one sessions with nursing staff to understand their care and treatment. We saw evidence of this in records. An occupational therapist supported patients and completed assessments.

Staff identified patients' physical health needs and recorded them in their care plans. Staff identified patients' physical health needs and recorded them in their care plans. Staff used the National Early Warning Scale 2, Lunsers, electrocardiograms, blood monitoring, venous thromboembolism monitoring and weight monitoring to assess and monitor patients' physical health.

Staff made sure patients had access to physical health care, including specialists as required. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Physical activities such as sports were built into patients' care plans and staff advised patients about healthy food options and smoking cessation.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The kitchen menus were colour coded to identify healthier meal choices for patients. Patients were encouraged to look at budget and cooking skills in relation to money management and eating healthier.

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

Staff used technology to support patients. Patients had access to Wi-Fi and mobile phones so they could keep in touch with people who mattered to them.

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

Audits included a weekly Venous Thrombosis Embolism (VTE), infection control (hand hygiene, ward cleanliness, mattress audits, and the emergency bags and its documentation audits

Managers used results from audits to make improvements.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. Staff teams included doctors, nurses, health care assistants, occupational therapists, and psychology staff. At the time of the inspection, the occupational therapist was working across 2 rehabilitation wards due to a vacancy

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. All staff working on Hazelwood ward were trained in dialectical behavioural therapy to a level relevant to their role. Staff were trained to use different techniques in line with this model. Although staff were sometimes moved between wards, there was always someone on the ward with the relevant training.

Managers gave each new member of staff a full induction to the service before they started work. New staff were supplied with a full local induction pack which contained all the mandatory information needed to work in the service as well as well-being events, staff room details, and ward information. Agency staff completed an induction checklist and observation competency checklist before commencing on shift and were encouraged to become regular staff members.

Managers supported permanent staff to develop through yearly, constructive appraisals of their work and compliance of appraisals was currently 92.6%.

Managers supported staff through regular, constructive clinical supervision of their work and compliance was currently 92%.

Managers supported newly qualified staff through a full preceptorship programme with induction packs and support in place.

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

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

Managers made sure staff received any specialist training for their role. Staff had been trained in supra pubic catheters, intermittent female catheterization, suture removals, compression stockings (how to undertake measurement and to apply stockings), and compression bandaging. Additional training had been delivered on NEWS2 for those staff identified through supervision and self-reflections. Further training on physical health care and care planning was due to take place in January 2024.

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

Multi-disciplinary and interagency teamwork

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

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

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended a handover meeting which was well organised and updated staff on all relevant information.

Ward teams had effective working relationships with other wards and managers supported each other. Staff were flexible to meet the needs of the hospital.

Ward teams had effective working relationships with external teams and organisations. This included home teams, the local police and safeguarding services.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Training compliance was currently 93%.

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 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. A general advocate visited the ward each week and patients confirmed they had met with them. The independent mental health advocate (IMHA) told us they felt able to support patients on the ward and were listened to in meetings. They told us there was a low referral rate for the size of the hospital.

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 requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

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

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

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's 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 95% and had a good understanding of at least the five principles.

Staff rarely made deprivation of liberty safeguard applications and there had been no applications made within the last 12 months. Patients were usually detained under the mental health act or admitted informally.

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 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 made and acted when they needed to make changes to improve.

Long stay or rehabilitation mental health wards for working age adults

Good

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We undertook detailed observations across all 3 wards as part of 'our observing, understanding, and influencing cultures' framework. We observed that staff had good rapport with patients and interacted while on observations. Staff were kind, caring and respectful towards patients.

We observed good interactions between staff and patients across all wards. We observed one negative interaction where a member of staff failed to introduce themselves to the patient whist doing observations. The patient asked the staff member for their name, which the staff member responded to.

Staff gave patients help, emotional support and advice when they needed it. Patients did say that this could vary when there were a lot of unfamiliar staff.

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

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

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

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

Staff followed policy to keep patient information confidential.

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.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us they felt listened to in meetings and felt that staff took their views into account.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

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

Patients could give feedback on the service and their treatment and staff supported them to do this during daily morning meetings and service user forms.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services. We saw posters displayed and saw evidence in records of this taking place.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers packs were sent out to families of patients on Linden ward and Dalton ward. Families were encouraged to from part of the assessment and monthly meetings took place involving families where appropriate.

Comments about staff were positive and carers understood about confidentiality and staff explained this. Some carers said staff were present during visits, but they understood why and felt staff made this easy.

Staff helped families to give feedback on the service. Staff were in the process of developing an online carers support group and were planning to arrange an open day for carers/families.

Staff gave carers information on how to find the carer's assessment. Social workers took the lead for 'think family' and Carers information boards were displayed in visitors' rooms on the wards and central visitors' rooms.

Is the service responsive?

Good

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

Access and discharge

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

The average bed occupancy on Linden and Dalton was 96% and 93% for Hazelwood.

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

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 during their stay 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.

Patients usually did not have to stay in hospital when they were well enough to leave. However, at the time of inspection there were 3 delayed discharges. 2 patients were awaiting Ministry of Justice authorisation to transfer to other hospitals, and the third patient was awaiting housing arrangements to be finalised.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise. We visited bedrooms on all 3 wards and spoke with patients who told us they were able to have their own belongings in their rooms and make them feel like their own.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. All wards had a communal lounge and dining area, activities rooms, sensory rooms and quiet areas.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could use areas off the wards. The site included a café and open spaces.

Patients could make phone calls in private and most had their own mobile phones.

Long stay or rehabilitation mental health wards for working age adults

Good

The service had an outside space that patients could access easily. The hospital was located on a large site with open and green spaces.

Patients could make their own hot drinks and snacks and were not dependent on staff.

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 on Hazelwood ward tended to have longer admissions due to the programme and staff supported patients to reintegrate back into the community prior to discharge. Patients were doing A levels at college, access courses, cookery courses, art at university and volunteering.

Staff helped patients to stay in contact with families and carers. However, the hospital was in a relatively isolated location, with limited transport links and patients told us they were encouraged to use phones and the internet to keep in touch with family and friends.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Information freely displayed in the wards on organisations external to the hospital and support groups for people with protected characteristics.

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. Staff had implemented a getting to know you task. This was between staff from different parts of the world and was a positive exercise for all staff and patients to support patients feeling comfortable with all staff.

Work was ongoing to understand different cultural barriers with sessions on cultural foods, patients' diversity and different languages One patient was having Spanish lessons.

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

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

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

Patients had access to spiritual, religious and cultural support and there were multi-faith rooms on site.

Listening to and learning from concerns and complaints

Long stay or rehabilitation mental health wards for working age adults

Good

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. There had been 10 complaints in the previous 12 months. 2 were upheld, 2 partially upheld and 6 were not upheld.

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.

Managers investigated complaints and identified themes. Complaints were reviewed through clinical governance meetings with the findings and response letters being shared with relevant people. Staff investigated complaints and shared the learning with those who made complaints and provided official response letters.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. This included updating the patient admission welcome pack and reminder that this should be given out on admission. Several complaints had been sent to the hospital through the CQC and work was ongoing to encourage patients to raise issues and concerns directly to ward staff where possible. A poster had been developed internally to show patients how to make an internal complaint.

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

Is the service well-led?

Good

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

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 had the skills, knowledge and experience to perform their roles. The wards managers had worked at the hospital in different roles for several years before becoming managers. Two had a significant number of years' experience.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. They could also explain what the current risks and challenges were and what measures were being put in place.

Staff within the service told us leaders were visible and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Long stay or rehabilitation mental health wards for working age adults

Good

Vision and strategy

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

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

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

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

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

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

Staff felt respected, supported and valued and most staff felt positive and proud about working for the provider and their team.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Experienced staff were committed to supporting less experienced staff and staff supported each other.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Managers were developing their own diversity & inclusion groups on site from early 2024.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. There were equality and diversity policies in place all staff were required to complete equality and diversity training. There were multi-faith rooms within the hospital and here were specific diversity and inclusion networks in the organisation including groups for; LGBT+ people, disabled people, menopause, neurodivergent people, armed forces, women men and, people from ethnic minority groups.

The provider recognised staff success within the service via staff awards and 'thank you' letters and emails. Those staff nominated for awards attended a site ceremony.

Managers told us they had introduced a celebratory lunch with the Hospital Director for staff who had worked at the organisation for 10 years. Staff had access to a coffee wellbeing fund and vouchers were given to staff.

The service's staff sickness and absence were similar to the average for the provider.

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

Managers kept in regular contact with staff who were away from work. Staff were directed to an employee assistance programme which included access to a counselling service. The provider's website included health and wellbeing advice.

Governance

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

Overall, the provider's governance systems were effective in ensuring patients received safe care and treatment and the hospital ran well. There were some issues with maintenance and cleanliness, on Dalton ward, which senior leaders had not yet taken appropriate action to address.

Staff were trained and received appraisals and supervision. Regular bank and agency staff were used who knew the wards and patients. appropriately. Staff knew how to handle complaints, assessed and managed risk well and knew how to report incidents and make safeguarding referrals to the local authority.

Staff managed beds well and planned for patients' discharges from the service. Staff were informed of lessons learned from investigating incidents, complaints, and safeguarding concerns. service's medicines management arrangements were safe and effective and ensured the effects of medicines on patients' physical health was regularly monitored.

There was a clear framework of what needed to be discussed at a ward, 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.

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

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.

Staff maintained and had access to the risk register at ward and hospital level. Staff at ward level could escalate concerns when required.

Staff concerns matched those on the risk register. The service had plans for emergencies – for example, adverse weather or a flu outbreak.

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 wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed including statutory notifications to CQC and safeguarding referrals to local authorities.

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. Information was available through the intranet, bulletins, and newsletters.

Patients and carers had opportunities to give feedback on the service. They received feedback in a manner that reflected their individual needs and were involved in decision-making about changes to the service.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service.

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

Leaders engaged with external stakeholders. Members of the senior management team met with commissioners from the Northeast and North Cumbria integrated care board on a quarterly basis or more frequently if required to discuss all key performance indicators they had set and any anomalies around trends, lessons learned and safeguarding.

The hospital director had recently been working alongside the Northeast and North Cumbria evolving group and Northeast and Cumbria integrated care board. This involved coming together as a collective group to look at quality standards for inpatients and strengthening the oversight and support arrangements for inpatient mental health services.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff on Hazelwood ward were committed to the delivery of the DBT programme and monitored DBT outcomes for patients.

Staff used quality improvement methods and knew how to apply them. These included quality walkarounds and assurance visits undertaken by members of the senior management team and the reducing restraint and interventions team.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure there are effective systems in place to ensure that all seclusion records are completed in line with the requirements of the Mental Health Act Code of Practice. The provider must ensure that all seclusion episodes are reported as incidents in line with their own policy and to ensure oversight and monitoring. 17 (1) (2) (a) (b) (c) • The provider must have in place effective systems to enable them to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). This includes but is not limited to improvements to internet access for patients and staff. 17(1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider must ensure that all wards are clean and well-maintained, by adequate numbers of housekeeping and maintenance staff to ensure the safety and wellbeing of all patients and to promote a therapeutic environment. This includes but is not limited to ensuring that all patients have continual access to hot water and adherence to infection control and safety protocols. 15 (1) (a) (c) (e)

This section is primarily information for the provider

Requirement notices

- The provider must ensure that improvements are made to the lighting and safety in relation to the exterior areas at nighttime to ensure staff, patients and visitors are safe in the hospital ground

15 (1) (b) (c)