Priory Healthcare Limited

The Priory Hospital Roehampton

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- This was a comprehensive inspection where we looked at the relevant key questions in full for acute wards for adults of working age and child and adolescent mental health wards. As a result of this inspection, the overall ratings for these two core services went down, from good to requires improvement. When combined with our ratings from previous inspections for the two other core services delivered at this site (hospital inpatient-based substance misuse services and specialist eating disorder services), we have rated two of the four core services provided at The Priory Hospital Roehampton as requires improvement. This means the rating for The Priory Hospital Roehampton has changed from good to requires improvement. We rated the hospital as requires improvement overall and rated the domain of safe, caring and well-led as requires improvement. Effective and responsive are rated as good.
- The service had made changes since our last inspection in February 2022 of the child and adolescent wards, but further work was needed to fully address the breach of regulation and to ensure that areas required for improvement were fully completed, embedded and sustained, particularly in relation to competence of agency staff and ensuring a strong leadership presence on the wards. Managerial and clinical leadership on the wards was in a state of ongoing change while permanent staff were recruited. This was having an impact on the leadership of the hospital while senior staff covered vacant posts.
- The service had some staffing challenges. They did not have enough permanent members of staff to cover all shifts in the child and adolescent wards. Managers covered vacancies using agency members of staff, but these staff were not always familiar with young people's needs. Patients also told us that agency staff did not always understand their personal space, and some carers said agency staff did not always communicate effectively with them.
- The service did not ensure that staff managed risks in the environment. Ligature risks and blind spots in the acute wards were not always well mitigated. Staff were not always present in inpatient areas to observe and mitigate risk. Some staff were not aware of what a ligature point was and therefore their mitigations. Whilst some parts of the wards had CCTV, these cameras did not always cover all communal areas of the wards.
- The child and adolescent wards were not always clean. Although the hospital kept cleaning records for the ward areas, these were not always effective, as parts of the ward environment on Lower Court were visibly dusty and cluttered. We found expired food in patient kitchens across all four wards inspected.
- At the time of inspection, staff had not completed all mandatory training. Some face-to-face training modules, such as immediate life support training and restraint, had low completion rates. The service did, however, have a plan to ensure staff completed the training. All staff were booked to complete training by May 2023.
- Team meetings on Garden Wing and Upper Court did not always cover all standard agenda points. Whilst lessons learned from incidents were shared across the hospital by senior staff, some staff we spoke with were unable to recall any learning from recent incidents. Handovers on Lower Court lacked structure.
- Staff did not always complete physical health checks. On Lower Court, staff did not always complete food and fluid charts for young people who had been identified as needing them. There were gaps noted when reviewing patient's medication administration charts on the acute wards. A patient who was on high dose antipsychotics did not have a completed form to show the patient's physical health was being monitored.
- Some staff felt it was sometimes difficult to work on the ward due to the difference in cultures. One staff member felt some staff were on Garden Wing were unprofessional. They felt managers who were not from an ethnic minority did not understand the problems they felt. However, managers attempted to support the team's cultures to blend, and they felt able to speak to managers with any concerns.

Summary of findings

- Not all patients and carers were adequately involved in services they received. For example, on the acute wards some patients were not adequately involved in decisions about their care, some did not have a copy of their care plan and ward community meetings were not always taking place regularly. On the child and adolescent mental health wards some carers we spoke with said that staff did not always keep them informed about their relatives' care and treatment, and generally communication was inconsistent.
- There was an overly restrictive blanket restriction in regard to leave for patients on the acute wards. Patients, including informal patients, on 4 hourly observations only had access to escorted leave If an informal patient wanted unescorted leave, this had to be assessed by a doctor, which meant a significant delay before a patient, for whom no legal authority for detention is in place, is allowed to exercise a legal right.
- On Upper Court did not have information on advocacy services available to patients. Signs explaining informal patient rights were not visible on either ward.
- Our findings from other key questions demonstrated that governance processes did not always operate effectively across the four wards inspected. For example, on the child and adolescent mental health wards, the provider's housekeeping procedures did not ensure all ward areas were effectively cleaned. There were lapses in recording of restraint and food and fluid chart documentation. On the acute wards, governance processes had not identified the areas needed for improvement on the wards. Staff participated in clinical audit, but where actions were identified, specific plans to address these areas were not made. Across both wards, there were no systems in place to ensure patient food had not expired in patient kitchens.

However:

- Since our last inspection of child and adolescent mental health wards in February 2022, some changes required from this inspection had been made. Agency staff now had access to patient records and regular supervision, staff had access to regular staff meetings and debriefs following incidents, there was now a clear care pathway in place to support admissions, and there were robust systems in place to learn from incidents. Despite these improvements, the provider's governance processes highlighted that Lower Court still required significant improvement during an internal assessment of the ward in December 2022. Senior management put an immediate action plan in place to support the performance of the ward. We found that the changes made had led to improvements, but time was required to ensure they were embedded consistently.
- The service was working hard to recruit and retain staff and they had an on-going recruitment plan in place. Staff block booked regular agency to support consistency on the wards.
- Staff assessed most risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and rapid tranquilisation only after attempts at de-escalation had failed. However, staff did not always record details about how physical restraint had been used.
- The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received supervision and appraisal. Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Most staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions. We observed caring and jovial interactions between staff and patients on Lower Court and Richmond Court.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed. They were visible in the service and approachable for patients and staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of the acute wards for adults of working age and psychiatric intensive care units went down. We rated it as requires improvement because: • We rated safe, effective, caring and well-led as requires improvement. We rated responsive as good. • The service did not ensure that staff managed risks in the environment. Ligature risks and blind spots in the acute wards were not always well mitigated. Staff were not always available in areas of the ward and garden to observe and mitigate risk. Some staff were not aware of what a ligature points was and therefore their mitigations. • Whilst some parts of the wards had CCTV, these cameras did not always cover all communal areas of the wards. • The clinic room on Upper Court was small and cluttered which might make it harder for staff to locate equipment when needed. • At the time of inspection, staff had not completed all mandatory training. Some face-to-face training modules, such as immediate life support training and restraint, had low completion rates. The service did, however, have a plan to ensure staff completed the training. All staff were booked to complete training by May 2023. • Whilst lessons learned from incidents were shared across the hospital by senior staff, some staff we spoke with were unable to recall any learning from recent incidents. • The ward multi-disciplinary teams were not always well connected with each other although team members felt this was starting to improve. • Staff did not always complete physical health checks. There were gaps noted when reviewing patient's medication

Summary of findings

administration charts on the acute wards. A patient who was on high dose antipsychotics did not have a completed form to show the patient's physical health was being monitored.

- There were food items in the fridge which had expired. There were no plans in place to manage and dispose of the food from patients who were no longer on the ward.
- There was an overly restrictive blanket restriction in regard to leave for patients on the acute wards. Patients, including informal patients, only had access to escorted leave. If an informal patient wanted unescorted leave, this had to be assessed by a doctor, which meant a significant delay before a patient, for whom no legal authority for detention is in place, is allowed to exercise a legal right.
- Upper Court did not have information on advocacy services available to patients. Signs explaining informal patient rights were not visible on either ward.
- Some patients were not adequately involved in decisions about their care, some did not have a copy of their care plan and ward community meetings were not always taking place regularly.
- Some staff on Garden Wing felt some staff were unprofessional. Some staff felt it was sometimes difficult to work on the ward due to the difference in cultures. They felt managers who were not from an ethnic minority did not understand the problems they felt. However, managers attempted to support the team's cultures to blend, and they felt able to speak to managers with any concerns.
- The governance processes had not identified the areas for improvement needed on the wards.

However:

Summary of findings

- The ward environments were well equipped, well furnished and well maintained. The wards had enough nurses and doctors.
- The rooms and furnishings of the hospital 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. Patients could make hot drinks and snacks at any time.
- Staff assessed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and rapid tranquilisation only after attempts at de-escalation had failed.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received supervision and appraisal.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Most staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed. They were visible in the service and approachable for patients and staff.
- Most staff felt respected, supported and valued. All staff could raise concerns

Summary of findings

			without fear. However, some staff felt that issues relating to staff cultures which were causing issues in people working together were not being addressed.
Specialist eating disorder services	**Not inspected**		We did not inspect specialist eating disorder services. When we last inspected the services in September 2020, we rated the service as requires improvement for safe. Our overall rating and rating for the other key questions remained as good.
Hospital inpatient-based substance misuse services	**Not inspected**		We rated hospital inpatient-based substance misuse services as good in May 2019.
Child and adolescent mental health wards	**Requires Improvement**		Our rating of this service went down. We rated it as requires improvement because: • We rated the service as requires improvement for safe, caring and well-led. We rated the service as good for effective and responsive. • The service had made some changes since our last focused and unrated inspection in February 2022 of the child and adolescent wards, but further work was needed to fully address the breach of regulation and to ensure that areas required for improvement were fully completed, embedded and sustained, particularly in relation to competence of agency staff and ensuring a strong leadership presence on the ward. • The child and adolescent wards were not always clean. Although the hospital kept cleaning records for the ward areas, these were not always effective parts of the ward environment on Lower Court were visibly dusty and cluttered. We found expired food in patient kitchens across all four wards inspected. • The service did not have enough permanent members of staff to cover all shifts in the child and adolescent wards. Managers covered vacancies using agency members of staff, but these staff were not always

Summary of findings

familiar with young people's needs. Patients also told us that agency staff did not always understand their personal space, and some carers said agency staff did not always communicate effectively with them.

- We observed a poor-quality handover on Lower Court. This meant that staff may not know about risks on ward.
- Staff had not completed all mandatory training. Some face-to-face training modules, such as immediate life support training and restraint, had low completion rates. The service did, however, have a plan to ensure staff completed the training. All staff were booked to complete training by May 2023.
- Staff did not always record details about how physical restraint had been used. On Lower Court, staff did not always complete food and fluid charts for young people who had been identified as needing them.
- Some carers we spoke with on Lower Court said that staff did not always keep them informed about their relatives' care and treatment, and generally communication was inconsistent.
- Some patients told us that the food quality was poor which had also been an issue at the inspection in 2021. One carer told us they brought in food for their relative to ensure their dietary requirements were met. The catering manager had been invited to a community meeting on Lower Court but did not attend. The provider was due to outsource to new catering company to improve food quality.
- Managerial and clinical leadership on the wards was in a state of ongoing change while permanent staff were recruited. This was having an impact on the leadership of the hospital while senior staff covered vacant posts. Whilst the provider was aware of this and the associated risks the work to address this was ongoing.
- Our findings from other key questions demonstrated that governance processes

Summary of findings

did not always operate effectively on the child and adolescent mental health wards. For example, the provider's housekeeping procedures did not ensure all ward areas were effectively cleaned and there were no systems in place to ensure patient food had not expired in patient kitchens. There were lapses in recording of restraint, and food and fluid chart documentation.

However:

- Changes had been made since our last inspection in February 2022 on Lower Court. Agency staff now had access to patient records and supervision, staff had access to regular staff meetings and debriefs following incidents, there was a clear care pathway in place to support admissions, and there were robust systems in place to learn from incidents.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. There was good access to therapies. We received positive feedback about the therapy staff.
- Most staff treated patients with compassion and kindness We observed caring and jovial interactions between staff and patients on Lower Court and Richmond Court. The environments were calm.
- Young people were able to feedback on the service they received via ward rounds and community meetings. In these meetings, staff and patients were able to give compliments to each other in the form of 'big ups'.
- At the last inspection in February 2022, the care pathway on Lower Court was not clear. At this inspection improvements had been made and there was a clear pathway to support patient admissions and how it was tailored to meet individual needs.

Summary of findings

- The provider's governance processes highlighted that the Lower Court required significant improvement and senior management put an immediate action plan in place to support the performance of the ward. However, this was in its infancy at the time of our inspection, and time was required to ensure improvements were consistently embedded.
- Staff said they felt supported by their colleagues, including senior management. They felt able to raise concerns with senior managers without fear of retribution.

Summary of findings

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Summary of this inspection

Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides support and treatment for people with mental health problems and substance misuse problems. There are seven inpatient wards at the hospital:

- Garden Wing (private acute ward for adults of working age)
- Upper court (private acute ward for adults of working age)
- West wing (private acute and addictions ward for adults of working age)
- East wing (specialist adult eating disorder ward)
- Priory court (specialist child and adolescent eating disorder ward)
- Lower court (child and adolescent mental health ward)
- Richmond court (private child and adolescent mental health ward)

This was a comprehensive and unannounced inspection of Lower Court and Richmond Court, the two child and adolescent mental health wards, and Upper Court and Garden Wing, the two acute wards for adults of working age. This included an out-of-hours unannounced inspection of Lower Court on 6 February 2023. We completed further telephone interviews with staff and families and carers following our on-site inspection. Our final telephone interview was on 14 February 2023.

We inspected these four wards due to an increase in the number of serious incidents reported to the CQC, which indicated there were risks to patient safety, and to check improvements made since our last inspection in February 2022.

The last inspection of this hospital was in February 2022, where we completed a focused inspection of Lower Court, one of the child and adolescent mental health wards, and looked at the domains safe, effective, caring, responsive and well-led. We found one breach of regulation. This was in relation to regulation 12 (safe care and treatment). The service did not ensure that persons providing care and treatment to young people had the competence, skills and experience to do so safely.

This location is registered to carry out the following regulated activities:

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

There was a registered manager in post at the time of the inspection.

What people who use the service say

Feedback from young people using the service was mixed across Lower Court and Richmond Court, the two child and adolescent mental health wards. Some young people we spoke with on Lower Court said that agency staff were often rude, did not make an effort with personal pronouns, and did not listen or have regard to personal space. Patients on both wards said the permanent staff were great. Young people told us that they enjoyed their therapy sessions and that there were enough staff on the wards.

Summary of this inspection

Carers feedback from Lower Court was mixed. Some said that staff did not always keep them informed about their relative's care and treatment, and communication was inconsistent. They said some of the permanent staff were very helpful, but sometimes there were too many different agency staff. One carer told us that there had been an improvement since the Director of Clinical Service for Operations had provided specialist support to Lower Court.

Patients feedback across Garden Wing and Upper Court was mostly positive. They were mostly very complimentary about their stay in hospital and the staff team. Patients told us staff were kind, helpful and professional. Patients told us they felt safe within these wards. Patients told us staff were eager to get to know them and were helpful when needing support. However, some patients said nursing staff were often overworked, which impacted on the amount of time they got to spend with them. One patient felt staff were sometimes patronising in the way they spoke to them.

How we carried out this inspection

During this inspection we carried out the following activities:

- Visited Lower Court, Richmond Court, Garden Wing and Upper Court, and looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with 12 patients who were using the service and 7 carers or family members of patients who were using the service. Interviews with carers were completed by telephone.
- Spoke with the hospital director, director of clinical services for operations, director of clinical services for quality, director of therapies and therapy leads for private adult and specialist services, mental health act administrator, complaints and compliance coordinator and the interim CAMHS medical director.
- Spoke with 30 other staff members including ward managers, consultant psychiatrists, ward doctors, registered nurses, health care assistants, assistant psychologists, assistant occupational therapists, ward managers.
- Attended and observed a day to night nursing handover on Lower Court
- Looked at 12 care and treatment records of patients
- Looked at all the prescription charts on Lower Court and Richmond Court, and 10 prescription charts across Garden Wing and Upper Court
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Inspection Team

The inspection was carried out by six inspectors, two inspection managers, two specialist advisors and two experts by experience.

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

Outstanding practice

We did not identify any areas of outstanding practice.

Areas for improvement

Action the service MUST take to improve on acute wards for adults of working age:

Summary of this inspection

- The service must ensure that ligature risks and blind spots are adequately mitigated on Garden Wing and Upper Court. All staff should be aware of what a ligature point is, and where they are located on the wards. (Regulation 12 (2) (b))
- The service must ensure that where wards use CCTV, there is consistent coverage across communal areas to support the safe care of patients. Reg 12 (2) (a) (b)
- The service must continue to ensure staff complete their mandatory training, in particular restraint intervention, safeguarding and immediate life support training, so they can deliver their roles safely.(Regulation 18 (2) (a))
- The provider must ensure they review the blanket restriction around arrangements for informal patient leave and consider more appropriate processes to ensure patients rights are upheld at all times. (Regulation 9 (3) (a) (b)
- The service must ensure Upper Court has information on advocacy services available to patients, and signs explaining information patient rights. Reg 9 (1) (2) (b)
- The service must ensure that all patients on the acute wards are involved in decisions about their care, and have a copy of their care plan. The service must ensure that ward community meetings take place regularly. Reg 9 (3) (b)
- The service must ensure that governance processes operate effectively to identify any improvements required for the acute wards. Reg 17 (1) (2) (a)
- The service must ensure that systems or processes are established to ensure ward areas are clean and well-maintained, including systems to ensure there is a plan in place to manage expired food in patient kitchens. (Regulation 17 (1) (2) (b))

Action the service MUST take to improve on child and adolescent mental health wards:

- The service must ensure that persons providing care and treatment to children and young people have the competence, skills and experience to do so safely. (Regulation 12 (1) (2) (a) (c))
- The service must ensure staff complete their mandatory training, in particular restraint intervention, safeguarding and immediate life support training, so they can deliver their roles safely. (Regulation 18 (2) (a))
- The service on Lower Court and Richmond Court must ensure staff inform and involve families and carers appropriately, and provide them with support where needed. Reg 9 (3) (g)
- The service must ensure that systems or processes are established to ensure ward areas are clean and well-maintained, including systems to ensure there is a plan in place to manage expired food in patient kitchens. (Regulation 17 (1) (2) (b))

Action the service SHOULD take to improve on acute wards for adults of working age:

- The service should ensure all medication administration records are completed in full, including any necessary medicine monitoring forms on Garden Wing and Upper Court.
- The service should ensure all patients are aware of their rights as informal and detained patients. All patients on Garden Wing and Upper Court should have access to information on advocacy services and the complaints procedure. Community meetings should occur in line with the hospital's guidance.
- The service should ensure team meetings on the acute wards cover lessons learnt from incidents, complaints and audits.
- The service should ensure action plans are created following audit findings on Garden Wing and Upper Court.
- The service should ensure there are enough doctors on the acute wards to complete a physical health examination on all patients in a timely manner.
- The service should ensure team meetings on Garden Wing and Upper Court cover all standard agenda points
- The service should make sure that ward multi-disciplinary teams are well connected with each other, so that they can effectively meet the needs of the patients.
- The service should ensure all staff from different cultures work together effectively as a team, and feel supported to do so by their managers.

Summary of this inspection

Action the service SHOULD take to improve child and adolescent mental health wards:

- The service should ensure that where physical restraint has been used, staff record details about how the intervention was implemented and the patient's response.
- The service should ensure that key risk information is effectively communicated during nursing handovers on Lower Court to mitigate identified risks.
- The service should ensure that staff complete food and fluid charts for patients who require them in order to meet their nutritional and hydration needs.
- The service should continue to work to provide stable clinical and managerial leadership to the children and adolescent mental health wards.

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	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Specialist eating disorder services	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected
Hospital inpatient-based substance misuse services	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected
Child and adolescent mental health wards	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Requires Improvement
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

Wards were clean, well equipped, well furnished, well maintained and fit for purpose. Whilst the ward assessed the ligature risks and blind spots on the wards, the risks were not well mitigated.

Safety of the ward layout

Staff completed and regularly updated a risk assessment of the ward areas. Ward areas contained potential ligature anchor points, for example, door handles, lamp wires and door hinges. Mitigations for these risks were ensuring staff were positioned in specific locations to view patient areas and ensuring some rooms were only used under staff supervision, such as the laundry room. However, we noted occasions throughout the inspection when nursing staff were not positioned in specific locations to observe patients. Staff positioning themselves in the corridors of Upper Court did not allow observation into the 2 lounges and kitchen area.

The wards contained blind spots. On Garden Wing, for example, there was a separate smaller corridor that led directly to the garden, and there were stairwells on both wards. The wards did not have convex mirrors to support a staff members line of sight for all blind spots. Staff told us patients were risk assessed prior to admission and the hospital would not accept someone who was high risk of self-harm or suicide. If a patient became high risk whilst on the ward, the patient would be nursed on 1:1 observation to ensure their safety.

Not all patient bedroom doors had viewing panels to allow staff to observe the patient when in their room with the door shut. Some lounge areas with ligature points had doors which could be closed, for example the female lounge on Upper Court. Staff told us they asked for the doors to remain open. If someone had the door shut staff would enter the room and offer the patient support.

The CCTV provision did not cover most of the communal areas of the wards. Garden Wing had CCTV covering the female corridor and the lounge. The staff we spoke with on Upper Court reported there was no CCTV on the ward.

The nurse in charge carried out routine checks of the environment 3 times per day to identify any matters that needed to be addressed.

Wards had 2 main corridors, which mostly separated male and female bed areas. Some rooms were used as mixed bed spaces. Upper Court he female lounge was located at the end of the male corridor. Staff reported a member of staff was situated in the corridor to enable them to ensure males were not able to access female designated areas. However, this was not always observed to be happening. There had been a recent incident where a male patient had accessed the female lounge.

The wards also had 2 rooms designated as 'safer rooms', which patients assessed as higher risk. These rooms were opposite the nursing stations and were fitted with anti-barricade doors.

The hospital had an alarm system which allowed staff and patients to summon assistance if required. These alarms were fixed to the walls. Staff did not carry personal alarms. The staff we spoke with reported feeling safe with these arrangements. Staff were able to carry portable radios with them to communicate if needed.

Patients had access to outdoor garden areas. On Garden Wing, an unlocked door led straight into the garden area. This meant patients were able to use this area without staff supervision. The garden area contained a tree and had blind spots. There was a low roof which some patients may have been able to climb onto. A yearly risk assessment was carried out for garden areas. The risk assessment stated garden fences were 220cm at its lowest. The hospital planned to add anti-climb paint onto these fences. Since the inspection, the hospital had carried out these planned works.

Fire safety arrangements were in place. Fire alarm tests occurred weekly. Fire drills occurred regularly for the hospital wards. Fire evacuation records were kept and documented how staff and patients evacuated the wards and any action points.

Personal emergency evacuation plans (PEEPs) were in place for most patients, however 1 patient on Upper Court did not have this in place. PEEPs consisted of a short sentence stating if the patient required support when evacuating the ward. For some patients who required support, there was no further detail on this form to state the specific interventions to support the patient. For example, a patient's PEEP stated they needed staff support due to hallucinations, however, no specific plans were documented on strategies to use.

Maintenance, cleanliness and infection control

The ward area was clean, well maintained, well-furnished and fit for purpose. All areas we viewed were clean and tidy. Furniture looked well maintained.

Housekeeping staff were seen cleaning the wards each day. Whilst areas were clean, staff on the ward were not able to locate cleaning records. These cleaning records were provided following the inspection.

A kitchen checklist should have been in place to ensure the area was well maintained, but this had not been completed by staff. There were food items in the fridge which had expired. The food belonged to a patient who had been discharged. Staff told us it was the patient's responsibility to remove their expired foods from the fridge. However, there were no plans in place to manage the food from patients who were no longer on the ward.

Staff adhered to infection control principles, including handwashing. There were posters above basins on effective handwashing techniques. The wards carried out yearly infection control audits.

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

Requires Improvement

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records were present to show the resuscitation equipment was checked once per week.

The clinic room on Upper Court was noted to be small, with lots of clutter, especially around the emergency equipment. This may result in some difficulty in accessing the equipment needed in an emergency. The infection control audit of Upper Court's clinic room from February 2022 noted inappropriate equipment was being stored in the clinic room. Resuscitation equipment was also held in the nursing office for easy access.

Stickers were placed on items within the clinic rooms to show they had been cleaned. However, the stickers were not dated to show when the cleaning took place. Some items within Upper Court's clinic room did not have these clean stickers, such as the height machine and weighing scales.

Room temperatures and fridge temperatures were monitored daily. Staff escalated concerns to seniors when temperatures exceeded recommended ranges.

Safe staffing

The service had enough nursing, who knew the patients. There were not enough junior doctors and so existing doctors were struggling to complete tasks in a timely manner such as completing physical health examinations. At the time of inspection, some mandatory training courses, especially those with face to face training modules, had low completion rates.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The nursing establishment across these wards had recently changed. The week before our visit, wards had 2 registered nurses and 1 healthcare assistant during the day and night. Following a recent serious incident, a second healthcare assistant was allocated each day. This additional staff member's main responsibility was to carry out risk assessments before a patient left the ward, and to escort patients on leave as required.

Managers assessed staffing requirements, using a staffing tool to identify how many staff should be on duty. This tool took into consideration how many patients were admitted and the level of enhanced observations on the ward. When there were more patients and a higher acuity of patients, more staff were booked to support patients.

Most patients reported there were enough staff, however, they could sometimes be too busy to meet with them for 1:1s. Staff told us this had been greatly improved following the recent additional allocation of a healthcare assistant. Staff told us they were able to spend more time with patients and were able support patients to access leave more easily.

The wards had reducing vacancy rates. At the time of inspection Garden Wind had 1.3 vacant registered nurse positions and 0.9 vacant healthcare assistant positions. Upper Court had 0.9 vacant registered nurse positions and 1.1 vacant healthcare assistant positions. Two registered nurse positions on Upper Court were due to be filled by healthcare assistants who had recently undergone their nursing training.

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

Requires Improvement

The use of bank and agency registered nurses for shifts across the wards varied over the last 12 months. For example, on Garden Wing in February 2022 bank staff covered 2% of registered nurse shifts and agency covered 42% of registered nurse shifts. On Garden Wing in December 2022, bank staff covered 46% of registered nurse shifts and agency covered 23% of registered nurse shifts.

The use of bank and agency healthcare assistants for shifts across the wards also varied over the last 12 months. For example, on Upper Court in April 2022 bank staff covered 20% of healthcare assistants shifts and agency covered 57% of healthcare assistants shifts. On Upper Court in September 2022, bank staff covered 25% of healthcare assistants shifts and agency covered 19% of healthcare assistants shifts.

Where possible managers requested bank and agency staff who had previously worked within the service. Managers were able to book bank and agency staff in block bookings, meaning they worked multiple shifts at the hospital.

No shifts were left unfilled in the last 12 months.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, 1 agency staff member told us they were not informed of the ligature points on their induction.

Turnover rates for the whole hospital site was 3.6% over the last 3 months.

Levels of sickness across the whole hospital were 4.5% over the last 3 months.

Staff shared key information to keep patients safe when handing over their care to others. The nursing team held handovers at the start of their shift. Handover notes were printed for each shift. Some staff told us these notes were very detailed and could feel like too much information was included. They also felt some information was repeated and irrelevant information was shared. However, other said they found the information helpful and enabled them to know the risks related to the patients.

Medical staff

There was adequate medical cover for both day and night and a doctor could attend the ward quickly in an emergency. The wards had permanent psychiatrists, as well as visiting psychiatrists. Visiting psychiatrists were not directly employed by the hospital. These psychiatrists attended the hospital when their community patients required an admission. They were responsible for the management of their patients care whilst they were admitted.

An out of hours rota for psychiatry cover was in place. All consultants with patients on the ward were contactable for queries at any time.

The wards had access to a ward doctor, these were often GP trainees. Some doctors told us they were needing to cover a range of wards due to shortages caused by sickness and annual leave. Other doctors told us there were sometimes delays in documentation and physical health exams when ward doctors were not available. The hospital had been looking for agency cover to support ward doctors however these gaps in the rota were not being filled.

Mandatory training

In general, staff completed and kept up to date with their mandatory training. In total, 85.6% of staff on Garden Wing had completed their mandatory training. On Upper Court 85.2% of staff had completed their mandatory training.

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

Requires Improvement

Both wards had low levels of completion for the hospital's reducing restrictive intervention training. On Garden Wing 54.2% of staff had completed this training, and 41.3% of staff on Upper Court had completed this training.

Garden Wing had low levels of training completion for immediate life support, where 13% of staff had completed this training. They also had low completion of combined safeguarding training for adults, children and young people, where 38.5% of staff had completed this training.

Managers had booked staff who had not completed these training courses onto upcoming sessions over the next couple of months.

Senior leaders within the hospital recognised some staff had low completion rates. The hospital had recently sent letters to staff members who had more than 3 training courses outstanding. The letters stated the staff had 2 weeks to complete their training. The staff member would need to meet with their manager if their training was still outstanding. If, after 7 more days, there were more than 3 courses still outstanding, the staff member would be suspended without pay until the training was complete.

Following the inspection, the hospital had increased their mandatory training compliance figures. Upper Court staff had completed 96.2% of their mandatory training and Garden Wing staff had completed 95.6% of their mandatory training.

Since the inspection, the hospital's reducing restrictive intervention training compliance had increased to 84.9% for Garden Wing and 83.3% for Upper Court.

Combined children and adults safeguarding had now been completed by 69.2% of staff on Garden Wing and 81.8% of staff on Upper Court. The remaining staff members had been booked onto training in May 2023.

One hundred percent of staff on both wards had now completed training in adult safeguarding.

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 rapid tranquilisation only after attempts at de-escalation had failed. However, not all staff were aware of what ligature points were and therefore their mitigations.

Assessment and management of patient risk

Staff completed risk assessments for each patient on admission. Staff reviewed this risk regularly.

Patient risk was discussed in handover meetings which were attended by all nursing staff on shift. The multidisciplinary team (MDT) reviewed patients' risks weekly at the individual patient's ward round.

Each patient's welfare was checked throughout the day by the nursing team. The frequency of these checks varied depending on the risks associated with the patient. Some patients were on continuous observations, which meant a member of staff was allocated to be with the patient at all times. Other patients were on intermittent observations, which involved staff checking in with them 4, 2 or 1 times per hour, depending on risks. Some patients were on general observations which was 2 checks within 24 hours.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw observation levels were increased or decreased depending on the changing risk level of the patient.

Staff knew the patients well and were able to discuss the risks associated with their presentations. The service had some banned items, which patients were informed about prior to their admission.

Following a serious incident on the ward the hospital implemented a new blanket restriction. The new guidance for leave stated all patients, even those who were informal, should only have escorted leave if they were being observed 4 times per hour by staff. Should an informal patient, on 4 hourly observations, refuse to be escorted on their leave, this decision would be risk assessed. The doctor would complete an assessment, as well as a capacity assessment. Should an informal patient, on 4 hourly observations, refuse to be escorted on their leave, this decision would be risk assessed. The doctor would complete an assessment, as well as a capacity assessment. The outcome would be documented during a psychiatrist's review to allow the patient unescorted leave. Informal patients would be able to leave the wards unescorted following this assessment. Staff told us the informal patients were accepting of this new guidance and, following a capacity assessment, they had consented to their leave being escorted. Consultants explained this change in policy was new and was under review at the time of inspection.

Staff told us they received training on the procedures of searching patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. In the last 12 months there had been 1 use of rapid tranquilisation on Garden Wing, and no usage on Upper Court.

Over the last 12 months there had been 13 incidents of restraint on Garden Wing and 3 incidents on Upper Court. None of these restraints were in prone position.

Training for reducing restrictive interventions was low for both wards. Managers had booked staff who's training had expired onto upcoming courses.

At the time of inspection, the wards were not involved in a formal reducing restrictive intervention programme.

Subject to an individual risk assessment, patients were able to use their own mobile phones whilst on the ward. One patient had a plan for their phone to be in the nursing office overnight as they were making calls to their family throughout the night. The wards planned to buy short charging cables to allow patients to charge their phones in their rooms.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed training on how to recognise and report abuse.

Not all staff kept up to date with their safeguarding training. Overall, 69.7% of staff on Garden Wing had completed safeguarding training. Eighty-six per cent of staff on Upper Court had completed this training.

Staff were also required to complete a combined adults, children and young people safeguarding training, however 38.5% of staff had completed this training on Garden Wing.

Managers told us they would book staff members onto these courses when needed.

The staff we spoke with knew how to recognise adults and children at risk of suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would inform their seniors and safeguarding leads with any concerns within the week. Out of hours, staff would speak with an on-call manager and raise concerns directly with the local authorities or police when needed.

The hospital had 2 safeguarding leads. There were posters displaying the contact details for the safeguarding leads and staff knew how to contact them for advice.

In the last 12 months Upper Court referred 25 cases to the local authority safeguarding team and Garden Wing referred 47 cases. Most of these referrals were related to the welfare and safety of their patients.

Patients had access to family visiting rooms off the ward where they could meet with visitors, including children.

Staff access to essential information

Staff had easy access to clinical information. Information was held both electronically and on paper records. There was sometimes confusion as to where information was being stored.

Patient notes were comprehensive, and all staff could access them easily.

The hospital mostly used electronic records. Physical health observations were recorded on a mixture of paper observation forms or on the online form. Some staff told us they completed both when recording observations, others were recording in 1 place. Following the inspection, the hospital sent us guidance from June 2021 that stated paper records were not required and suggested staff only used the online system to record observations.

Documents, such as team meeting minutes or community meeting minutes, were not always held in the same electronic shared folders. This meant staff did not always know where to access some information.

Bank and agency staff who had worked more than 3 shifts had access to this online system and could add to the notes when required.

Records were stored securely. All staff required an individual username and password to access the electronic patient record system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we noted some gaps when reviewing medication administration charts. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

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

Requires Improvement

Staff followed systems and processes to prescribe and administer most medicines safely. Nurses administered medicines and signed prescription charts to show they were given as intended.

We reviewed 10 medicine administration charts. Of these, 1 did not have the allergy box completed, 2 did not have any initials to state a medicine had been stopped and 2 had a signature missing when a medicine was due to be administered. One chart did not have the patients Mental Health Act status completed, and 1 other chart recorded the patient as being informal despite them being detained under section 2 of the Mental Health Act.

Ward managers kept a log to ensure registered nursing staff had completed their medicines competency tests. These logs showed staff across both wards had completed this competence.

One patient had been prescribed a high dose of antipsychotic treatment, but there were no forms in place to show staff were monitoring the patient's condition, physical health and side effects. This was raised with staff at the time and we were informed this form had been completed that day.

Doctors reviewed each patient's medicines at weekly ward rounds, and they provided advice to patients and carers about their medicines. Patients were able to meet with a pharmacist to discuss their medicine if they wanted this.

Staff stored and managed all medicines and prescribing documents safely. Medicines and prescription charts were kept in the locked clinic room.

Staff reviewed the effects of each patient's medicines on their physical health. When patients were admitted, an attempt was made to take baseline blood tests and electrocardiogram (ECG) readings.

Safety alerts related to medicines and audit findings were shared with psychiatrists via email.

Track record on safety

Within the last 12 months there had been 6 serious incidents on Garden Wing and 4 serious incidents on Upper court. The provider's threshold for determining if an incident was a serious incident was lower than that required in NHS services.

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. However not all staff were able to recall lessons learnt from an incident. When things went wrong, staff apologised and gave patients honest information and suitable support.

The hospital had an electronic system for recording incidents. All staff had access to this system to facilitate prompt reporting. Staff knew what incidents to report and how to report them.

The incidents on Garden Wing included 3 incidents of staff falling asleep whilst on patient 1:1 observation. The ward manager investigated these incidents.

The serious incidents on Upper Court included 2 ex-patient deaths and 1 attempted ligature incident.

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

Requires Improvement

Staff feedback was mixed in regard to receiving debriefs after an incident. Some members of staff reported debriefs occurred following more serious incidents. Staff told us they will speak with patients after an incident to offer support. Reflective practice sessions were offered weekly to the ward teams by a psychologist. These were free spaces for staff to discuss any concerns or incidents they wanted to discuss.

Changes had been made as a result of incidents. For example, following a recent patient death, the wards were trialling a new risk assessment that needed to be completed prior to a patient leaving this ward. This risk assessment included a detailed description of the patient's clothes, their mood and how they were planning to spend their leave.

Whilst lessons learned from incidents were shared across the hospital by senior staff, some staff we spoke with were unable to recall any learning from recent incidents. Some staff said this was because incidents were rare across the wards. Local lessons learnt were shared with staff following governance meetings and through the weekly hospital director email. In addition, Priory-wide learning was shared with all staff each month via email in a news bulletin.

Staff understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires Improvement

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

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. Physical health observations were not always carried out in line with the patient's plan.

Staff completed a comprehensive mental health assessment of each patient prior to admission and again once they had been admitted.

When patients were admitted they were reviewed by a doctor for an initial assessment, which included a physical health assessment and an assessment of their risk.

Staff developed care plans for patients that met their mental and physical health needs. Care plans had limited details. However, they captured the views of the patient and documented the plans for admission.

Care plans were reviewed regularly through multidisciplinary discussion and updated as needed.

Most patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. This included blood tests and electrocardiograms (ECGs) where needed.

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

Requires Improvement

Staff did not always complete and record physical health checks fully. We reviewed 8 paper physical health charts on Upper Court. Two charts indicated that observations needed to be completed daily, but these had not been completed. Nursing staff did not always complete the scoring of their observations, and some entries were not signed by the nurse completing the assessment. One patient did not have a physical health observation chart.

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 did not always use recognised rating scales to assess and record severity and outcomes. Staff participated in clinical audit, but not all staff could explain the learning from audits. Where actions were identified, specific plans to address these areas were not made.

Staff provided a range of care and treatment suitable for the patients in the service and it was consistent with national guidance on best practice. Treatments were delivered in line with guidance from the National Institute for Health and Care Excellence (NICE). Doctors prescribed medicines appropriately with input from pharmacists to ensure that national guidance was followed. Psychologists provided group therapy session, individual therapy and music therapy for patients.

All patients met with the therapy team on admission. A therapist explained to the patient the therapies the hospital offered. Following the assessment and discussion, the patient was supported to attend a group therapy programme that most fit their needs.

At the time of inspection, the therapy team had 2 main therapy programmes. One programme focused on understanding a diagnosis and beginning to manage their symptoms. The other programme was more intensive for people nearing discharge. Due to the rise in acuity of the patients at the hospital, the therapy team had created a third therapy programme. This programme was aimed at those who were still unwell with a focus on grounding techniques. This programme had been organised and staffing had been arranged, but the team was not able to start this programme due to the lack of available rooms to provide therapy in.

All programmes had 4 group sessions a day. Patients could also receive weekly 1:1 sessions with a psychologist.

Staff made sure patients had access to physical health care, including specialists as required. For example, staff supported patients to appointments with a dermatologist and a neurologist.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a gym. Patients were supported by fitness instructors who carried out risk assessments on patients prior to them using the facilities. Patients were also able to access a swimming pool and take part in equine therapy.

The therapy team carried out diagnostic questionnaires to determine patient progression. The medical team used feedback from ward staff, the patient and carers to assess the patient's condition and progress.

The hospital had an occupational therapist.

Staff took part in clinical audits. A range of audits were carried out on the wards. Audits reviewed areas such as infection control, care notes and compliance with the Mental Health Act.

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

Requires Improvement

Senior staff within the hospital carried out quality walk round audits for each ward. Senior staff reviewed patient records and spoke with staff and patients. However, when actions were identified, there was not always a specific plan in place to address the concerns. For example, staff found documentation of personal information needed to be updated. The plan stated the record should be updated, it but did not indicate by who and by which date. The audit was not updated to state these outstanding areas had been completed. There was also no follow up action recorded following the patient providing their feedback on the therapy offered.

The risk assessments audit on the ward noted 1 record required updating to meet guidance. However, this action did not have further information on who was responsible for updating the records, and by which date.

Staff were not always aware of findings or improvements from audits. The team meeting minutes reviewed did not show a discussion on audits. However, doctors were able to discuss receiving audits from the pharmacy, with action points to follow up.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The hospital's kitchen was able to cater to dietary requirements. However, a patient told us the food quality was poor for the food intolerances they had. This patient was providing their own food to eat on the ward.

Skilled staff to deliver care

The ward teams 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. Team meetings did not always cover all standard agenda points.

The service had a full range of specialists to meet the needs of the patients on the ward. For example, nurses, healthcare assistants, doctors, and psychologists.

There were no vacancies within the therapy team and medical team. However, some doctors reported it would be useful to have more than 1 ward doctor allocated to a ward due to workload.

Managers gave each new permanent member of staff a full induction to the service before they started work. Managers kept a log of who's induction was outstanding.

Managers supported staff through regular, constructive clinical supervision of their work. Staff on the ward had monthly clinical supervision, as well as monthly managerial supervision. At the time of inspection, 80% of staff on Garden Wing received supervision and 82% of staff on Upper Court had received supervision. Managers kept a log of supervision for their wards.

The psychologists held reflective practice for the nursing team weekly to discuss any patient cases or concerns.

Junior doctors received supervision once per week and attended weekly sessions with their course supervisors. The hospital had a psychiatrist who led on supporting junior doctors and their welfare. Junior doctors could approach this psychiatrist, as well as their supervisors for support.

Managers supported staff through constructive appraisals of their work. All staff on the ward had an appraisal in the last 12 months.

The ward action plan for Garden Wing stated team meetings should occur every week, but these did not always happen. The latest team meetings were documented as 2 February 2023, 19 January 2023, 5 January 2023 and 8 December 2022. Attendance at these meetings ranged from 3 staff to 6 staff. From November 2022 these team meetings were due to occur every 2 weeks.

Team meeting documentation had a standard agenda to ensure meetings covered health and safety matters, policy updates, learning from complaints and specific ward updates. Whilst some meetings covered learning from complaints and incidents, this was not seen at all team meetings. Not all agenda points were discussed at each meeting. This, along with team meetings not occurring regularly, could lead to important information and updates not being shared with staff.

Records were kept following these meetings. However, these minutes were not always held in the team meeting folder on their shared drive.

Managers recognised poor performance, could identify the reasons for this and dealt with these. A ward manager gave examples of recognising and managing poor performance. For example, having open discussions with the staff member during supervision and receiving advice from the central human resources team where needed.

Multi-disciplinary and interagency team work

Some staff said different disciplines worked together as a team to benefit patients. Others felt the teams could feel disjointed. Staff 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.

Staff discussed a patient's care as a multidisciplinary team during a patient's weekly ward round. Ward rounds were attended by a psychiatrist, ward doctor, nurse and therapist.

Some staff told us the multidisciplinary team can sometimes feel disconnected. They felt the nursing team, the therapy team and the medical team were separate teams, despite all working with the same patients. Some staff told us therapy staff were not always informed of ward round times, meaning they could not attend these meetings. Other staff told us they felt there had been a recent improvement in the team feeling more connected and felt able to discuss care with all multidisciplinary team members.

Ward doctors and senior staff members attended flash meetings for updates related to patient care each morning.

Nursing handover meetings took place between shifts. Handover minutes were very detailed. Some staff told us there was too much information shared, which was often repeated. Others told us the amount information shared was helpful.

The ward had effective working relationships with other teams within the hospital. For example, the ward managers attended meetings with other seniors from the hospital to discuss any safety concerns at the weekly patient safety meetings.

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

Requires Improvement

The permanent consultant psychiatrists for the acute wards had a weekly meeting for case discussion. All consultants, including vising consultants, attended a monthly meeting for case discussion, and to share information and updates from the hospital.

The medical director had an informal weekly drop-in clinic where any doctor could seek support.

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. However, Upper Court did not have information on advocacy services available to patients. Signs explaining informal patient rights were not visible on either ward.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice.

The compliance rate for this training was 84.6% on Garden Wing, and 91.3% on Upper Court.

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.

Staff had access to in-house support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had a Mental Health Act administrator to support the ward with their detained patients' documentation.

The administrator kept a spreadsheet to keep track of the necessary paperwork and alerted ward managers and doctors when information was needed.

Staff knew to contact the Mental Health Act administrator for support when needed.

Some patients had easy access to information about independent mental health advocacy. We saw a poster for the advocacy service on Garden Wing, however this information was not seen on Upper Court.

Records showed staff explained to patients their rights under the Mental Health Act. However, there was no information available to informal patients explaining their rights, such as signs on the doors explaining their right to leave the hospital.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. All original paperwork was kept in the Mental Health Act office. Copies of these documents were kept on the wards and in a patient's online file.

An audit was carried out in 2022 to ensure the service applied the Mental Health Act correctly, however, at the time of audit, no patients on either ward were detained. The audit did not state the date the audit took place.

Good practice in applying the Mental Capacity Act

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

Requires Improvement

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

Staff received training in the Mental Capacity Act. The compliance rate for this training was 92.3% for Garden Wing and 91.6% for Upper Court.

If staff had concerns about a patient's capacity, they would raise the concerns with the senior ward staff or the doctors on the ward.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed doctors assessed capacity and consent on admission.

The service monitored how well it followed the Mental Capacity Act. The wards completed a yearly audit to ensure their capacity assessments were carried out in line with hospital policy.

Is the service caring?

Requires Improvement

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

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. However, a patient reported staff were often busy and another reported staff were sometimes patronising in their tone.

Patients were mostly very complimentary about the staff. They reported staff were kind, helpful and professional.

Staff were discreet and responsive when caring for patients. Most patients attended a full therapy schedule during the day, therefore ward areas during the inspection were quieter. We saw some examples of staff interacting with patients in a kind and caring manner. Most patients spoke positively about their experiences on the ward. Patients said staff treated them well and behaved kindly. One patient felt staff sometimes spoke to them in a patronising tone.

Staff gave patients help, emotional support and advice when they needed it. Patients told us when they needed support and spoke to staff, they were very helpful.

Staff supported patients to understand and manage their own care and treatment. Patients told us they had enough time to discuss their treatment plans with health professionals throughout the week and in their ward rounds.

Staff directed patients to other services and supported them to access those services if they needed help. For example, a patient told us they were referred to the neurologists for investigations.

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

Requires Improvement

Staff understood and respected the individual needs of each patient. For example, staff told us about patient's dietary requirements, and said they had recently supported a client who did not speak English.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. However, some patients told us they did not have access to their care plans, and some did not know about advocacy services. In general, community meetings did not occur regularly.

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission. Some patients told us they had been to these wards previously, so did not need a tour of the environment on this admission.

Staff involved patients in their care planning. Patient views were included in their care plans, in their own words. However, some patients told us they did not have copies of their care plans.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were able to give feedback to any staff member. The hospital also had a formal complaints process. There were leaflets available on this on Upper Court, but leaflets were not seen in communal areas on Garden Wing.

Community meetings did not always happen. A weekly community meeting was due to take place on the wards. At these meetings, patients were able to meet with the ward team to discuss any of the concerns as well as receive updates on the ward. For example, on Garden Wing the last community meeting was held on 20 January 2023. The last documented meeting prior to this was held on 27 October 2022. During these meetings patients raised concerns there were no staff available to support them during nursing handovers. They also raised a concern that some night staff were inexperienced and were not familiar with the individual patients or wards. The ward manager attended this meeting and offered time to meet with patients individually to discuss their concerns further.

At the end of each day, ward staff held an informal reflection space. This was for patients to think about the day they have had and inform the nursing team of any concerns they had.

Not all patients were aware of the advocacy services available on the ward. Information posters about advocacy services were displayed on Garden Wing, however these were not observed on Upper Court. Patients told us if they had a concern, they felt the ward teams were able to support them.

Staff involved patients in decisions about the service, when appropriate. For example, patient representatives attended the hospital's senior governance meeting to provide direct feedback from patients to senior leaders.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, a carer told us they would have benefitted from having a carers specific admissions booklet, with useful information such as the complaints procedure and visiting arrangements.

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

Requires Improvement

Patients told us their families were involved in their care and staff members kept their family updated on their care. When family members were involved in the patient's care, staff contacted carers following incidents.

Family members were invited to attend ward rounds virtually. This ensured carers had a place to ask questions as well as kept up to date with the treatment plans.

We spoke with 1 carer who reported they had good communication with the ward and staff were friendly. However, they did not know how to raise a complaint, or how to contact the managers. They also suggested a carers admission pack would be useful as they felt some information had not been shared. For example, they were unsure of the visiting arrangements for children. The governance meeting minutes from January 2023 stated admission booklets for both patients and carers were being created.

The hospital did not have any carer groups for the patients on these wards, and family therapy was generally not offered during inpatient treatment.

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. In general, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Garden Wing and Upper Court were privately funded wards. They therefore did not take NHS referrals.

The hospital had a referrals team who managed referrals to the wards. When a new referral was received, the team contacted the on-call consultant for the ward. This consultant would assess the patient to ensure they were suitable to be admitted to the hospital. For example, the hospital did not admit patients who were high risk of suicide or self-harm. Other referrals came from visiting psychiatrists who were looking for an inpatient bed for their outpatient patients.

Managers made sure bed occupancy did not go above 85%. Over the last 12 months, bed occupancy for Upper Court averaged 11.4 beds and Garden Wing 11.5 beds.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for patients was around 28 days in line with most privately funded insurance company policies. Length of stay could be shorter or longer than the average, depending on patient needs.

The wards did not have a catchment area. It admitted patients from all over the country as needed.

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

Patients rarely moved between wards. This would only happen 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. However, some staff mentioned it would be helpful to have set admission times throughout the day, to allow easier planning and allow more structure on the ward.

Discharge and transfers of care

Patients did not have to stay in hospital when they were well enough to leave. However, there was a patient admitted to Upper Court who had been on leave since 20 December 2022. This patient was awaiting a final medical review before their discharge, but they had not attended the ward for this meeting.

Staff planned patients' discharge during their admission. The consultant overseeing the patients care in hospital was, in most cases, the consultant who would see the patient in the community for outpatient appointments. The hospital had a day service where patients could continue to access therapy whilst not staying at the hospital as an inpatient.

Facilities that promote comfort, dignity and privacy

The rooms and furnishings of the hospital 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. Patients could make hot drinks and snacks at any time.

Each patient had their own bedroom with an en-suite bathroom. Patients could personalise their bedrooms if they wanted. Patients had a secure place to store personal possessions. Staff held keys for these cupboards which were located under patient beds. Restricted items were held securely by staff and could only be accessed under staff supervision.

Staff used a full range of rooms and equipment to support treatment and care. For example, a gym, a range of therapy rooms, kitchens, lounges and a café.

The service had quiet areas and a room where patients could meet with visitors in private. This included a room off the ward where patients could meet with children.

Patients could make phone calls in private. Patients had access to their own personal mobile phones, which could be used in the privacy of their bedrooms.

The service had an outside space that patients could access easily. Garden Wing was on the ground floor therefore patients had direct access to the garden area, which remained unlocked. Upper Court patients were able to visit the garden with staff supervision, unless risk assessed to use this area unescorted.

Patients could make their own hot drinks and snacks and they were not dependent on staff. Patients had access to a kitchen on both wards. There was fresh fruit available for patients.

The service offered a variety of good quality food. Most patients said the food was nice. However, 1 patient said the wards did not cater to their individual intolerances and therefore provided their own food.

Patients' engagement with the wider community

Staff supported patients to maintain contact with those that mattered to them.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and in the wider community. This included supporting patients to stay in contact with families and inviting them to ward rounds with the patient's consent.

Meeting the needs of all people who use the service

In most cases, the service met the needs of patients, such as those with a protected characteristic. However, the wards were not able to accommodate a patient who used a wheelchair. Staff helped patients with communication, and cultural and spiritual support.

In some cases, the service could support and make adjustments for people with specific needs. For example, ensuring documentation was in an easy read format. The wards were not, however, suitable for someone with mobility issues. Upper Court was on the first floor with no lift facilities. Whilst Garden Wing was on the ground floor there were stairs leading from the main entrance.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us they were able to book interpreters when their recent patient did not speak English. However, there were no signs informing patients of this option.

The hospital had a multifaith room which could be used by all patients.

The wards had information boards. On Garden Wing this had advocacy service details, information on safeguarding procedures and information related to therapy and the gym. On Upper Court, noticeboards had information on how to make a complaint, blanket restrictions and data protection. Information was not available on local services and patient's rights.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, lessons from complaints were not always shared with all teams.

Patients and carers were able to raise any concerns with the ward directly. There was a formal complaints route as well as an informal feedback route.

The ward encouraged patients to provide informal feedback to staff regularly. This included in their daily reflection, community meeting or at ward rounds.

Upper Court displayed information about how to raise a concern in patient areas. However, this was not in patient areas on Garden Wing.

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

Requires Improvement

Patients told us they felt able to raise concerns with staff.

Staff understood the policy on complaints and knew how to handle them. A senior member of staff was allocated to investigate complaints depending on the concern raised. In the past 12 months, there had been 9 formal complaints on Garden Wing and 1 formal complaint on Upper Court. The wards noted themes from these complaints, such as communication and quality of care.

Learning from complaints was used to improve the service. For example, some complaints were a result of patients having high expectations of the service that did not match what was available. Senior staff reported these had reduced following communication with all visiting consultants on the therapy options available at the service.

Garden Wing team meeting minutes showed learning was shared with the team around a recent medication complaint. However, learning from complaints was not documented in the Upper Court team meeting minutes reviewed.

The service used compliments to learn, celebrate success and improve the quality of care. We saw thank you cards in nursing offices from past patients and carers. Staff were encouraged to log the compliments they received, however some staff told us this process could be time consuming.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Staff told us the ward managers and hospital seniors were present on the ward. The senior staff we spoke with had a good understanding of the service they managed, as well as their patients' needs, risks and circumstances.

Staff said they found their managers to be visible and approachable. They could get support from them when they needed it. Staff told us senior leaders within the hospital had an open-door policy and were able to speak with them when needed. Staff felt comfortable raising issues directly with senior staff members and they were confident these would be addressed.

Leadership development opportunities were available, and staff were encouraged to develop skills and competencies. For example, the ward manager on Garden Wing had started on the ward as a staff nurse.

There were also opportunities for those below this level to develop. The hospital had recently supported some healthcare assistants to complete their training to become registered nurses.

Vision and strategy

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

Requires Improvement

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

The hospital provider had values and behaviours that their service aspired to be. Those were, putting people first, being supportive, acting with integrity, striving for excellence and being positive.

The staff we spoke with were able to talk about the values and demonstrate how they were meeting them. For example, they felt most staff were caring and respected patients, putting the patients' needs first. Staff also spoke of feeling supported within the hospital.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, staff informed us that some consultation had taken place about the potential to change the patient group on a ward. Following an open discussion with staff, the decision was made to not make any changes.

Culture

Most staff felt respected, supported and valued. All staff could raise concerns without fear. The hospital had processes to promote equality and diversity in its daily work and provided opportunities for development and career progression. Whilst staff reported good team working within the nursing team on the wards, some staff reported concerns in relation to how cultural issues were sometimes managed.

In general, staff reported good team working within the nursing staff on the wards. However, some staff on Garden Wing reported feeling disrespected and unwelcomed by their nursing colleagues. Another staff member commented some staff could be unprofessional.

Some staff reported good team working across the whole multidisciplinary team. Others felt the different disciplines were sometimes disjointed.

Staff felt able to approach anyone within the multidisciplinary team for support and advice

Most staff knew about the whistleblowing procedure and how to raise concerns in this way if needed. Staff told us they felt able to approach their hospital seniors with any concerns directly.

Staff had access to support for their own physical and emotional health needs through an employee assistance programme.

Nursing staff received managerial supervision as well as clinical supervision. An allocated psychologist also provided reflective spaces for staff.

Managers dealt with poor staff performance when needed. Managers gave clear examples of the process they followed to manage poor performance. This included providing additional support and disciplinary action when necessary. Managers had support from the Priory's organisation-wide human resources team as needed.

Prior to the pandemic, the wards had away days to support team bonding and team training. Ward seniors reported they were planning on reimplementing these days.

The hospital recognised staff success within the service. Staff were able to vote for employee of the quarter within the hospital.

Staff provided examples of where the managers had been supportive of personal adjustments and flexible working. For example, to support those staff who had caring responsibilities.

The provider had equality network groups for staff, such as the disability and difference network and the black and ethnic minority network. These networks and meeting times were shared in the weekly hospital director email.

Some staff felt it was sometimes difficult to work on the ward due to the difference in cultures. They felt managers who were not from an ethnic minority did not understand the problems they felt. They also commented managers were sometimes afraid to make decisions and intervene to avoid potentially offending someone. They did, however, also note that managers attempted to support the team's cultures to blend, and they felt able to speak to managers with any concerns.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at senior level. Team meetings did not always cover the key agenda points. Training compliance in some key areas was low. The ward's environmental risks were not always well mitigated. Whilst audits were carried out, they did not always have action plans to address any areas of improvement.

Leaders had structures, processes and systems of accountability for the performance of the service in place. For example, audits and the quality walk rounds. However, when issues were identified through audit, they were not always followed with specific plans to address the area of concern. For example, the quality walk round for Upper Court found a patient did not feel involved in their care, did not have 1:1 time with nursing staff and did not feel the therapy programme fit their individual needs. However, there were no plans documented on how the team would follow up on the information they received. This audit on both wards found gaps in documentation, but there were no specific plans in place to address this. The latest record review for Upper Court did not review patient's physical health and medication charts as part of their review.

Whilst there were systems in place for senior staff members to review training, compliance for the wards was low in some areas, such as restraint training. Senior leaders had recently sent formal letters to staff members with outstanding training, asking them to complete the training within 2 weeks.

Staff were clear about their roles and accountabilities. Staff had opportunities to meet, discuss and learn from the performance of the service. However, team meetings did not always occur weekly.

There were a range of meetings where senior staff met to discuss any concerns. For example, weekly ward manager meetings, monthly head of department meetings and monthly senior management team meetings. Minutes were kept for all of these meetings.

Whilst the wards had completed risk assessments of their patient areas, ligature anchor points and blind spots remained. The hospital's mitigations for these risks were staff observations of patient areas. However, we noted times during the inspection that these mitigations were not always in place.

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

Requires Improvement

There was a clear framework of what must be discussed in hospital level governance meetings to ensure that essential information such as, incidents, safeguarding concerns, complaints and operational issues was shared and discussed. However, these same topics were not standard agenda points in the ward team meeting. These areas were sometimes covered, but not in every meeting. This could therefore lead to some information and learning not being shared with the team. Following the inspection, the hospital implemented a standardised team meeting agenda. This agenda included topics such as clinical governance, risk, incidents, and quality improvement.

Following a governance meeting, the hospital produced a hospital governance bulletin which highlighted the main topics of discussion. This included a summary on areas such as incidents, safeguarding concerns, complaints, compliments, and recruitment.

The hospital director sent out weekly emails. The emails included information such as, a link to the monthly lessons learnt bulletin, any new policies, the freedom to speak up contact details, and a note welcoming new staff. The email also included good practice and lessons learnt from other Priory hospitals.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at ward level. For example, ensuring staff risk assessed patients prior to leave.

Staff participated in local clinical audits. Audits were carried out on areas of care such as care planning, risk assessments, the Mental Health Act and infection control. However, when concerns were highlighted the wards did not always document specific plans, with allocated staff members, and time frames for the actions to be completed.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks.

Seniors had oversight of the main risks on the ward. Staff working on the ward could escalate their concerns to seniors via the ward manager. Staff concerns on the wards matched those main risks, for example, staffing levels and the newly implemented leave risk assessment.

Seniors at the hospital met regularly to discuss risks for the service and their patients. This happened in meetings such as patient safety meetings, ward manager meetings and governance meetings.

The wards had previously struggled to recruit nurses and support workers. At the time of inspection, they had, however, been successful in filling many of their nursing posts. This was helped by supporting their healthcare assistants to train as mental health nurses and recruiting international nurses.

The hospital had reviewed patient safety following incidents. For example, following a recent death of a patient on leave, the service began trailing a new pre-leave risk assessment form to ensure the patients were safe when they leave the ward.

Information management

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

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

Requires Improvement

The service used systems to collect data from the wards that were not over-burdensome for frontline staff. The ward manager and senior staff had access to information to support them with their management role. This included information on the performance of the service through audits and staffing.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure generally worked well and helped to improve the quality of care. However, some staff told us the hospital's internet connection would sometimes not work. Following the inspection, the hospital completed upgrade works on their internet, including improvements in their broadband speeds.

Information governance systems included confidentiality of patient's records. Online records were held securely, requiring passwords to access information. Paper records were held in locked staff areas, such as the nursing office and clinic rooms.

Staff made notifications to external bodies as needed. The service submitted statutory notifications to CQC when required.

Engagement

Patient, carers and staff were able to provide feedback to the service. However, the carer was unaware of the complaints process. Team meetings and community meetings in general did not occur weekly.

Staff and patients had access to up-to-date information about the work of the service, for example, through emails, team meetings and community meetings. However, team meetings and community meetings were not always held in line with the hospitals recommended timeframes.

There were no carers meetings on the acute wards for adults of a working age. One carer mentioned an admission handbook with useful information specifically for carers would have been helpful. According to the hospital's recent governance meeting, they were in the process of creating these booklets.

Patients were able to provide feedback in community meetings, reflective sessions, direct to staff, or through the formal complaint's procedure. However, the carer we spoke to was not aware of the hospital's complaint procedure.

Patient representatives were invited to attend senior governance meetings to discuss the feedback they had received from their peers.

Learning, continuous improvement and innovation

Wards did not routinely collect and analyse data regarding patient progress. Some staff were supported to carry out improvement projects on the wards.

Whilst psychologists used tools to assess patient's conditions, the wards did not routinely use patient outcome measures to monitor patient progression whilst they were on the wards.

A quality improvement project had recently begun on the acute wards looking into the physical health management of their patients. This project was started by a GP trainee and was specifically looking to improve the cardiac risk screening of their patients. The results of these screenings were acted on and shared with the patient's GP on discharge.

Specialist eating disorder services

Hospital inpatient-based substance misuse services

Requires Improvement

Child and adolescent mental health wards

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

Wards were generally well equipped, well-furnished and fit for purpose. However, despite staff keeping up-to-date cleaning records for the wards, these were not always effective as we still found areas of the ward environment on Lower Court to be dusty, unclean and cluttered. Out of date food was found in the patient fridges.

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.

The ward layouts did not allow staff to observe all areas, but staff used regular observation in line with patients' risk assessment to mitigate risks. The provider had installed convex mirrors to reduce blind spots. The service had closed circuit television (CCTV) throughout the communal areas of the wards.

Lower Court was based across two floors with seven bedrooms on the ground floor and five bedrooms on the upper floor. Staff escorted young people when they accessed the upper floor. A staff member was present if there were patients using the second floor. At the time of our inspection, all seven patients had bedrooms on the ground floor.

Seven of the ground floor bedrooms had en-suite bathrooms. The five bedrooms upstairs shared a bathroom. Staff placed young people of the same gender upstairs.

Richmond Court was based across a ground floor with six bedrooms, which had en-suite bathrooms. At the time of the inspection, all six bedrooms were occupied.

Requires Improvement

Child and adolescent mental health wards

Staff had completed a ligature risk assessment for each ward that identified ligature anchor points in February 2022. A ligature anchor point is an environmental feature of structure that patients may fix a ligature with the intention of harming themselves. The ligature risk assessment identified blind spots on the ward. Ligature cutters were clearly displayed in the nursing office for easy access. Staff personal alarms had ligature cutters attached to them for easy access. Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe.

All lower ground rooms had magnetic en-suite bathroom doors, an anti-ligature radiator cover and non-weight bearing curtains. All bedrooms had anti-barricade doors.

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

Staff carried out regular planned fire drills and false alarms. The last planned fire evacuation was in July 2022, coordinated by the fire marshals. All the young people responded correctly.

Maintenance, cleanliness and infection control

Despite staff keeping up to date cleaning records for the wards, these were not always effective as we still found areas of the ward environment on Lower Court to be dusty, unclean and cluttered. The group room was cluttered and cushions and beanbags visibly dusty. The sensory room was not well-maintained and one bedroom on the lower floor had a hole in the wall and this was being repaired. A carer told us there were balls of dust in their relative's bedroom. This issue was raised with the provider who told us that each ward had a named domestic who cleaned the wards daily, alongside four annual cleanliness audits and quality spot checks. The sensory room was due to replaced. The provider was due to outsource the cleaning to a new company.

We found expired food in the patient fridges across the two wards and there was no clear process to manage this. For example, on Lower Court, food had been out of date since September 2022. Opened food and milk did not display labels to indicate opening dates, and food containers were dirty and sticky. Staff were unsure of whose responsibility it was to manage this. This was highlighted during the inspection, and we were told this issue would be added to the ward's 'back to basics' training and nursing staff would take responsibility in managing this going forward.

Richmond Court ward area was clean, well-maintained and well-furnished.

Staff adhered to infection control principles, including handwashing. The hospital completed an infection prevention and control audit in February 2022, which covered handwashing, clinic rooms and ward department cleanliness. There were no concerns raised for Lower Court or Richmond Court.

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. On both wards, the clinic room equipment appeared clean but there were no stickers to indicate date that it was cleaned.

Safe staffing

Requires Improvement

Child and adolescent mental health wards

The service did not have enough permanent members of staff to cover all shifts in the child and adolescent wards. Managers covered vacancies using agency members of staff, but these staff were not always familiar with young people's needs. Whilst mandatory training rates for the wards were good overall, there were essential face-to-face training modules that had low completion rates.

Nursing staff

Whilst the service had a robust improvement plan for the recruitment and retention of qualified and non-qualified staff, the service still relied on high use of agency members to ensure all shifts were covered on the child and adolescent wards. The issues we found at our previous inspection of Lower Court in February 2022, relating to the competence, skills and experience of some agency staff, continued. For example, we found some examples of agency staff not being aware of patients' care plans or making poor decisions relating to patients' clinical care. The provider had plans in place to help address this. The night-time site coordinator completed quality spot checks each night on the ward, and the three senior nurses on the ward were due to complete night-time quality reviews on the ward to assess staff culture.

At the last inspection in February 2022, vacancy rates for nurses and the use of agency staff were slowly reducing. At this inspection, we found some improvements.

On Lower Court, the service's vacancy rates had improved since our last inspection in February 2022. Vacancy rates for nursing staff reduced from 50% to 30% (establishment levels for nursing staff was 8.1 and there were 2.4 vacancies. The establishment levels for healthcare assistants was 10.2 and there were 2.3 vacancies.

However, vacancy rates on Richmond Court were higher than the last inspection in February 2022. Nursing vacancy rates increased from 40% to 84% (establishment levels for nursing staff was 6.1 and there were 5.1 vacancies. At the time of the inspection, plans were in place to fill these posts. A regular locum nurse was in the process of onboarding to become permanent, and interviews were lined up during the week of inspection for a registered nurse and lead nurse post. The establishment levels for healthcare assistants was 6.10 and there were 3.1 vacancies.

The number of shifts filled by bank or agency staff where there were sickness, absence or vacancies between January 2022 to December 2022 was 2974. The shifts covered by bank and agency registered nurses and healthcare assistants were often very familiar with the ward. The service had employed additional agency healthcare assistants to offer extra support in response to rising acuity. The provider reported that there were no shifts not filled by bank or agency staff where there was sickness, absence or vacancies in the last 12 months.

Managers told us that all bank and agency staff had a full induction and understood the service before starting their shift. We found that not all paperwork for local ward induction for permanent and bank and agency staff was completed in full. The acting ward manager was aware of this and was taking steps to address this.

The hospital's staff turnover monthly average for the last 3 months was 4.5%. In the last 12 months, it was 4%. The provider was unable to report this by ward.

Managers supported staff who needed time off for ill health. Staff said their managers were understanding and supportive when managing ill health.

Levels of sickness were reducing on Lower Court. For example, In January 2022, 73.5 hours of sickness were reported for registered nurses and 209 hours for healthcare assistants, and this reduced to 37 hours for registered nurses and 60 hours for healthcare assistants in December 2022.

Requires Improvement

Child and adolescent mental health wards

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

The ward manager could adjust staffing levels according to the needs of the children and young people.

A qualified nurse was always present in communal areas of the wards.

Children and young people had regular one-to-one sessions with their named nurse on Lower Court. On Richmond Court, it had been highlighted that not all young people were having regular one-to-one sessions with their named nurse. This was addressed in February's 2023 community team meeting to ensure one-to-one sessions took place and recorded in patient care records.

Staff told us that there were no incidents where children and young people had their escorted leave cancelled when the service was short staffed. However, some young people and their carers told us that there were not enough staff on wards to escort young patients onto grounds leave.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Since our last inspection in February 2022, there had been several changes to the consultant psychiatrist cover on Lower Court. This impacted the consistency and leadership usually provided by the consultant psychiatrist on the ward. The full-time consultant had left and there had been a series of locum consultants. At the time of the inspection, there were two part-time consultant psychiatrists on Lower Court (one was employed on a locum basis and one on a permanent basis who was also the consultant for Richmond Court). They were providing temporary cover until a full-time consultant psychiatrist was employed. Interviews for this post were being held in March 2023.

The medical director for child and adolescent mental health services (CAMHS) and specialist services was on maternity leave at the time of our inspection and was due back in March 2023. Upon their return they would step back into their additional role as consultant for Richmond Court. Between June 2022 and October 2022, there had been a period without a medical director for CAMHS and specialist services. Since October 2022, there was an interim medical director for CAMHS and specialist services in place.

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

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The average mandatory training rate for permanent staff was 83% for Lower Court and 82% for Richmond Court. There was a cross site plan to deliver 90% of all mandatory training by March 2023. Some staff told us that they did not have enough time to complete all their outstanding mandatory training.

On Lower Court, some staff were not up to date with their mandatory training. Fifty-three per cent of staff had completed safeguarding combined: adults, children and young people. All staff were booked to complete this by 13 March 2023. Sixty per cent of staff had completed immediate life support training. All staff were booked to complete this by May 2023.

On Richmond Court, some staff were not up to date with their mandatory training. Thirty-three per cent of staff had not completed immediate life support training. All staff were booked to complete this by May 2023. Fifty-seven per cent of staff had completed reducing restrictive intervention training. Staff had been pre-booked on courses to achieve 85% by the end of March 2023, and 95% by the end of April 2023.

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

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

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. However, staff did not always record details about how physical restraint had been used and the handover we observed did not discuss all key risks.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool.

Management of patient risk

We reviewed six care records during our inspection. They demonstrated that staff did a risk assessment of every patient on admission and updated it regularly.

Staff identified and responded to any changes in risks to, or posed by, children and young people. For example, if there were specific times of increased risk for a young person, additional staff would support the young person.

Staff discussed new and existing risks at ward rounds, handovers and team meetings. The handover we observed on Lower Court did not discuss key risks, even though the handover document was comprehensive.

Staff followed procedures to minimise risks where they could not easily observe children and young people. This was mainly through regular observations.

Staff followed provider policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Before the inspection, we were made aware that some agency staff members did not carry out search procedures in line with provider policy. The provider was already aware of this issue and had developed a training day for all staff.

Staff applied blanket restrictions on patients' freedom only when justified. For example, young people handed in their mobile phones at 10.30pm in order to encourage good sleep hygiene and engagement in their therapeutic timetable the following day. If a young person had a therapeutic need for their mobile phone at night, this was reviewed, and care planned.

Young people admitted to the ward were aware of their rights to leave the ward. Staff considered the risk to young people before leave and where appropriate contacted parents of the young people. The provider had recently piloted a new risk assessment called the 5-point risk assessment which staff completed when patients went on leave. The provider had recently secured the hospital building and staff escorted all patients (including informal patients) to be signed in and out of the hospital when they used leave. This process was being reviewed by managers in a month's time to see if the pilot would continue.

Use of restrictive interventions

Staff completed keeping safe care plans for young people. These included plans on how to support young people using the least restriction as possible.

Staff had been trained in the use of restraint and completed records when restraint was used. However, we found an example on Richmond Court where an incident of restraint was not recorded in full. It was not clear which staff members were involved in the restraint, what sort of holds were used and for how long.

In the last 12 months before the inspection, staff on Lower Court recorded 271 incidents of restraint. None of these incidents involved prone restraint. During the same time period there were 74 incidents of rapid tranquilisation.

In the last 12 months before the inspection, staff on Richmond Court recorded 7 incidents of restraint. None of these incidents involved prone restraint. During the same time period 23 incidents of rapid tranquilisation was used.

Staff received training in reducing restrictive intervention training. This helped staff manage situations that involved conflict and aggression. Staff discussed ways in which to reduce the use of restraint in team meetings.

Staff completed physical healthcare checks for young people following administration of intra-muscular rapid tranquilisation. We reviewed two incidents of intra-muscular rapid tranquilisation that demonstrated staff followed the provider's policy, and it was in line with the National Institute for Health and Care Excellence (NICE) guidance. The hospital maintained a rapid tranquilisation monitoring tracker. Senior managers reviewed incidents of rapid tranquilisation at the daily hospital-wide 'flash' meeting.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe.

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

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Most staff kept up to date with their safeguarding training. Eighty-one per cent of staff had completed safeguarding training on Lower Court, and 71% on Richmond Court.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. At the last inspection in February 2022, not all agency staff had a full understanding of safeguarding in relation to children and young people. This meant that some staff may not always recognise children and young people at risk of or suffering harm and therefore fail to raise safeguarding concerns when needed. At this inspection, we did not find this to be the case. The agency staff we spoke with understood how to make a safeguarding alert.

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

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

In the last 12 months, there had been 213 safeguarding incidents on Lower Court, and 46 on Richmond Court. The majority of these were self-harming incidents, followed by welfare concern.

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

The service maintained a safeguarding log which tracked each safeguarding incident, reports to the local authority safeguarding team and immediate actions to safeguard the individual. This was monitored by the services two social workers who were the safeguarding leads.

Staff access to essential information

Staff had easy access to clinical information. Information was held both electronically and on paper records.

At the last inspection in February 2022, agency staff who were not registered nurses did not have access to patient records. This meant that agency staff relied on communication at handover meetings for information and updates on patients' risk. At this inspection, this was not the case. All agency staff members had access to a log-in to access patient records to support them to safely deliver their role. This was addressed in the ward's action plan.

Patient notes were comprehensive, and all staff could access them easily.

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

Records were stored securely.

Medicines management

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

Requires Improvement

Child and adolescent mental health wards

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

We reviewed all the young people's medicine records which were fully completed. Young people's medicines charts recorded potential allergies.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines.

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

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

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

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

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Track record on safety

Staff reported serious incidents clearly and in line with provider policy. The provider's threshold for determining if an incident was a serious incident was lower than that required in NHS services. In the last 12 months there had been 19 serious incidents on Lower Court, and 3 serious incidents on Richmond Court. Most of these related to self-harm (4), alleged abuse (4), serious injury (3) and staff asleep on 1 to 1 (4), absconding (4), and police involvement (1).

Reporting incidents and learning from when things go wrong

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

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

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

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if things went wrong.

Staff told us that they received feedback from investigation of incidents, both internal and external to the service. Staff received a weekly email from the hospital director, which detailed feedback from investigations across the Priory hospitals.

Requires Improvement

Child and adolescent mental health wards

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Managers delivered specific training days to staff as a result of investigations into incidents. There was a training day in December 2022, which covered topics such as handover communication and risk management. This helped improve the safety on the ward.

At the last inspection in February 2022, debriefs following incidents on Lower Court did not take place. At this inspection, we found improvements. Staff told us that managers debriefed and supported them after serious incidents.

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

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

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 children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery oriented.

We reviewed six care records during our inspection. Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after.

Children and young people 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 child or young person that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when children and young people's needs changed.

Care plans were personalised, holistic and recovery orientated.

Staff completed regular care plan audits. We reviewed the last two care plan audits for both wards, which demonstrated patient involvement, but observation levels did not always match care plans.

Best practice in treatment and care

Requires Improvement

Child and adolescent mental health wards

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people 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. However, staff did not always complete patients' food and fluid charts where required.

The multi-disciplinary team provided a range of care and treatment suitable for the children and young people on both wards. These interventions were in line with National Institute for Health and Care Excellence (NICE) guidance. The service had a timetable of therapy-based groups that young people could engage with such as art therapy, yoga, dialectical behavioural therapy (DBT), baking skills, crocheting, mindfulness, movement, equine and pet therapy, and one to one clinical psychology.

Staff identified children and young people's physical health needs and recorded them in their care plans. For example, where a young person was celiac this was clearly flagged in their care plans.

Staff responded to specific physical health needs. However, on Lower Court, for one young person who had a food and fluid chart in place, it was not clear on the amount of food or fluid intake. This meant there was no assurance if food or fluid intake was enough. We found another example, on Lower Court where a young person had a food and fluid plan in place but there was no food intake record.

Staff made sure children and young people had access to physical health care, including specialists as required. We saw evidence of staff supporting young people to access specialist medical care when required.

Staff helped children and young people live healthier lives. We saw evidence of staff supporting young people with smoking cessation.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. For example, staff measured patients' outcomes using the Health of the Nation Outcome Scale for Children and Adolescents and the Children's Global Assessment Scale.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, staff completed audits of health and safety, medicines management, care plans, and reducing restrictive practice. Audits were discussed in clinical governance meetings and action was taken to address concerns identified in these audits.

Skilled staff to deliver care

The ward teams included or had access to a range of specialists required to meet the needs of children and young people on the wards. Although the therapy team was largely made up of locum staff, and some were due to soon leave the team. 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. However, not all paperwork for local ward induction for permanent, bank and agency staff were completed in full.

Both ward teams included or had access to a range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, clinical psychologists, occupational therapists, pharmacists, a family therapist, social workers and an advocate. However, there had been an issue sourcing an independent mental health advocate with recruitment ongoing.

There had been a high turnover of therapy staff across Lower Court and Richmond Court. Whilst at the time of inspection, the therapy roles were all filled, they were mostly filled via locum positions. The provider highlighted that this presented a risk as they were able to leave at short notice. The assistant psychologist and assistant occupational therapist were due to leave the week following our inspection and the roles were out to advert. The social worker on Lower Court was also due to leave.

We were told that the high turnover of therapy staff on Lower Court, particularly the psychologist input was due to high workload. The provider had recently introduced three part-time therapy roles to support the psychologist. The clinical psychologist on Lower Court was employed on a locum basis and started in January 2023 and was on a rolling contract until a permanent post was filled.

Lower Court had also been without a regular ward clerk and we were told that this lack of ward clerk support meant various ward administration processes were not being completed on time. Such as sending out CPA administration and responding to emails being sent to the ward email inbox by carers. This was raised with managers during the inspection who told us that a temporary ward clerk would be joining the team immediately until a permanent post was filled.

Most staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. However, the competency of night-time agency staff on Lower Court had been highlighted as an area that required extra support following several recent incidents. The provider had plans in place to help address this. The night-time site coordinator completed quality spot checks each night on the ward, and the three senior nurses on the ward were due to complete night-time quality reviews on the ward to assess staff culture.

All staff had an appraisal in the last 12 months on both wards.

The percentage of staff that received regular supervision in the last 12 months on Lower Court was 82%, and 68% on Richmond Court. Staff told us that they were able to discuss their wellbeing, personal and professional development and to reflect on and learn from practice. Group reflective practice had recently started once a fortnight.

At the last inspection in February 2022, regular agency staff did not receive supervision. At this inspection, improvements had been made and all agency registered nurses received regular supervision. This meant agency staff had a dedicated space to discuss their wellbeing and reflect on practice.

Managers made sure staff attended regular team meetings or gave information for 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. The provider identified specific training needs for staff on Lower Court. They developed 'back to basics' training days and staff development days which addressed these needs. For example, the staff development day in December 2022 covered the search procedure following an incident on the ward.

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 children and young people. They supported each other to make sure children and young people 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 children and young people and improve their care. At the last inspection in February 2022, staff meetings on Lower Court did not regularly occur. At this inspection, this was no longer the case. We saw minutes from the last three staff team meetings, which were held weekly and were generally well attended. Meetings were held face to face and virtually to enable the whole team to attend.

Nursing staff held handovers twice a day between shift changes. We observed a poor-quality handover on Lower Court during our evening inspection. The handover did not engage the healthcare assistants present. Some staff turned up late during the handover. The handover lacked structure and was not risk focused. The director of clinical services for operations was aware that the handover quality was variable and was providing support to the nursing team. The regional head of quality was looking to pilot the provider's new handover document on Lower Court to support improvement.

The wards held weekly ward rounds where young people were seen alongside their multi-disciplinary team.

Ward teams had effective working relationships with other teams in the organisation. Nursing staff provided daily handovers to teaching staff at the onsite school.

Ward teams had effective working relationships with external teams and organisations. We saw good examples of staff engaging with a young person's community team and secondary school to support their care and treatment.

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 children and young people's 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. On Richmond Court, 86% of staff had training in the Mental Health Act. On Lower Court, 82% of staff had training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

Children and young people had easy access to an advocate that visited the ward weekly. However, there was no independent mental health advocate (IMHA) on the ward as the service had challenges sourcing an IMHA.

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

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

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

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those children and young people 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. We reviewed the mental health act / mental capacity act audit for 2022 for 3 patients on Lower Court. There were no issues found.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

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

On Lower Court, 94% of staff had training in the Mental Capacity Act. On Richmond Court, 85% of staff had training in the Mental Capacity Act.

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.

For young people under the age of 16, staff used the Gillick competence test. The Gillick competence is used by staff to decide if a child 16 years or younger is able to consent without the need for parental permission. Medical staff recorded and updated capacity assessments clearly in young people’s records. For example, where staff assessed a young person’s capacity to make a specific decision.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history.

Requires Improvement

Child and adolescent mental health wards

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Most staff treated children and young people with compassion and kindness, and they respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition. However, some patients told us that agency staff were sometimes rude and did not always understand their individual needs.

Most staff were discreet, respectful, and responsive when caring for children and young people. Patients told us that permanent staff were great. However, some patients we spoke with on Lower Court said that agency staff were often rude, did not make an effort with personal pronouns, and did not listen or regard personal space.

We were told about an example where a domestic staff member on Richmond Court walked into a patient's bedroom without knocking or acknowledging them and emptied their mop bucket into their en-suite toilet. The provider acted immediately and addressed conduct with domestic staff and made an apology to the service user.

During our inspection, we observed kind, positive and responsive interactions from staff on both wards. Staff showed compassion and interest in the young person's wellbeing.

On Richmond Court, the young people had been learning how to crochet and found this very enjoyable. The patients proudly displayed their crochet items on the ward.

Staff supported children and young people to understand and manage their own care treatment or condition. For example, young people told us that they understood their medicines they were on and associated side effects.

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

Staff followed policy to keep patient information confidential. The nurses' office contained a white board with patient information that would be used during handovers, but it was kept covered up when not in use to keep the information confidential.

Involvement in care

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

Involvement of children and young people

Requires Improvement

Child and adolescent mental health wards

Staff introduced children and young people to the ward and the services as part of their admission.

Staff involved children and young people and gave them access to their care planning and risk assessments. Young people told us they met with their named key worker regularly where they discussed their care plans and talked about risk. They met with their co-worker, normally a healthcare assistant, on a weekly basis, or more frequently when needed. Updates from these meetings would be shared with the young person's family when necessary.

Staff encouraged young people to give feedback about the ward. Young people were able to provide feedback in weekly community meetings and ward rounds. Staff responded to feedback from young people. They completed a 'you said / we did' board on the ward to let young people know they had responded to their concerns. They also gave 'big ups' during community meetings where they delivered compliments to other patients and / or staff.

Staff made sure children and young people could access advocacy services. An advocate visited the ward weekly.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Some carers we spoke with on Lower Court said that staff did not always keep them informed about their relatives' care and treatment, and generally communication was inconsistent. They told us that sometimes staff provided an update following ward round, and sometimes they did not. One carer told us that staff did not keep them up to date with their child's upcoming transfer to adult services. One carer fed back that since the director of clinical services for operations joined the ward that communication had improved.

Some carers told us that they were not able to feedback on their relative's ward rounds. One carer told us that they emailed a feedback form to the ward ahead of their child's ward round, but this information was not used as no one was monitoring the ward email inbox. We raised this during our inspection and immediate action was taken. Staff were assigned to monitor the ward email inbox and the ward manager printed copies of family feedback forms and placed them by the ward entrance for parents to take. This issue was also addressed in the latest team meeting.

Carers told us the permanent staff were great, but that there were sometimes too many agency staff.

The hospital recognised that more work was needed to improved engagement with families and carers. The therapy lead for CAMHS and specialist services at the hospital was in the process of setting up a carers support group for Lower Court and Richmond Court. At the time of the inspection this was in the process of being established.

Is the service responsive?

Good

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

Access and discharge

Requires Improvement

Child and adolescent mental health wards

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

Lower Court and Richmond Court provided Tier 4 specialist in-patient care to young people who were suffering from severe and/or complex mental health conditions that could be adequately treated by community CAMHS services.

The ward manager liaised with the referring agency to agree timescale for admission. Prior to admission, members of the multi-disciplinary team spoke to referring team to discuss the young person's needs and purpose of admission. Most young people were funded by NHS England on Lower Court, whereas young people were privately funded on Richmond Court.

Over the last 12 months, Richmond Court (6 beds) reported an average bed occupancy of 3.5, and Lower Court (12 beds) reported a bed occupancy of 10.

The service was responsive to the needs of patient and staff on the wards. Admissions to Lower Court had been capped at 7 patients whilst the improvement plan was being implemented and embedded.

At the last inspection in February 2022, the care pathway on Lower Court was not clear. At this inspection improvements had been made. There was a clear pathway to support patient admissions and how it was tailored to meet individual needs and different psychiatric conditions.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned.

Staff did not move or discharge children and young people at night or very early in the morning.

The hospital did not have a psychiatric care unit. If a young person needed more intensive care, managers made the necessary arrangements with external providers.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well.

Requires Improvement

Child and adolescent mental health wards

Staff supported children and young people when they were referred or transferred between services. We saw an example of a young person who was due to turn 18 years old, and staff were organising a transfer to an adult bed as they were not ready for discharge.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The rooms and furnishings of the wards supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. However, young people told us the food was not of a good quality.

Each or young person had their own bedroom, which they could personalise. We observed bedrooms that had personal belongings and decorations.

Children and young people had a secure place to store personal possessions.

Staff and young people had access to a full range of rooms and equipment to support treatment and care. This included a lounge, activity room, a self-soothe room, a communal kitchen and a clinic room with an examination couch.

The service did not have a room where children and young people could meet with visitors in private. Young people saw visitors in their bedrooms or in the group therapy room.

Children and young people could make phone calls in private. Staff assessed whether young people could use their own mobile phone on an individual basis.

The service had an outside space that children and young people could access easily. The ward had a secure garden. Individual risk assessments were carried out when patients wanted to access the garden and one member of staff would be present in the garden when it was in use.

Children and young people could make their own hot drinks and snacks and were not dependent on staff.

Some patients told us that the food quality was poor. This was in issue picked up in our inspection in April 2021. “At this inspection, one carer told us they brought in food for their relative to ensure their dietary requirements were met. We saw that food was addressed in patient community meetings, where it was reported that young people were not eating the food as they did not like what was offered, and they did not find it child friendly. We saw that the catering manager was invited to the community meeting but did not attend and would be invited again. The provider was about to change its caterer, and it had sent out a food survey to patients to gather dietary preferences to inform the new provider.

On Lower Court, there were two Guinea pigs that staff and patients cared for. The young people we spoke with told us they enjoyed caring for them.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Young people had access to education onsite, and staff assisted them to explore other education opportunities.

Staff supported young people to maintain contact with their families and carers. Young people told us they spoke with their families regularly, and often saw them for grounds leave or home leave.

Meeting the needs of all people who use the service

In most cases, the service met the needs of patients, such as those with a protected characteristic. However, the wards were not able to accommodate a patient who used a wheelchair. Staff helped patients with communication, and cultural and spiritual support.

The ward could not admit young people with mobility difficulties due to the environmental layout. Staff would assess young people on referral and, if required, refer them to other services that offered full disability access.

Young people told us that staff using their correct pronouns was important to them. Young people's preferred pronouns were displayed on a board on both wards, at their request. They told us that permanent staff referred to them by their correct pronouns, but sometimes agency staff did not.

Staff ensured that young people could obtain information on patient rights and the complaints procedure. This was clearly displayed on a notice board in the communal area. The information was clear and was written in language that was accessible to young people.

The hospital had a linked school located on the site, Priory Lodge, which supported young people to continue to receive education during their admission. The Office for Standards in Education, Children's Services and Skills (Ofsted) rated the school as Good in May 2019.

The service generally provided a variety of food to meet the dietary and cultural needs of individual children and young people. We were told that there were not always gluten free options for a celiac patient. This was raised with managers who told us that catering staff do cater for all dietary requirements.

Children and young people had access to spiritual, religious and cultural support. The hospital had a chaplaincy service that young people could contact if they wished.

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. However, not all carers knew how to make a complaint.

In the last 12 months there had been 6 formal complaints on Lower Court, 1 was upheld, 2 partially upheld and 2 not upheld. These were mainly to do with staff attitude and staff communication. On Richmond Court, there were 5 formal complaints, 2 were upheld, 3 partially upheld and 1 not upheld. These were mainly to do with parental expectations around staff communication.

Children and young people knew how to complain or raise concerns. Some relatives and carers that we spoke with did not know how to complain or raise concerns.

Requires Improvement

Child and adolescent mental health wards

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

Staff protected children and young people who raised concerns or complaints from discrimination and harassment. Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

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

Managers investigated complaints and identified themes. The provider's complaints and compliance officer monitored the management of all formal complaints and ensured that they were responded to withing the provider's timescales.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback and learning from formal complaints were discussed in monthly clinical governance meetings.

The service used compliments to learn, celebrate success and improve the quality of care. All compliments were recorded on the electronic record system and monitored by the complaints and compliance officer. These included the 'big up' compliments feedback by the young people in community meetings.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff. However, the provider had identified that some of the senior leadership team were relatively new to leadership roles and required extra support. The provider also identified leadership on Lower Court needed support.

The provider had identified the leadership of the senior management team (SMT) as a risk on the hospital's risk register. This was because several of the SMT were relatively new to leadership roles and / or some were new in post, and one senior staff member was due to leave. This was in addition to the experienced director of clinical services for operations who had stepped down to provide frontline leadership to Lower Court. This had added extra pressure to the site's hospital director. To mitigate these risks, the provider's regional head of quality was on-site twice a week offering support to the SMT where needed and this risk was being monitored regularly via the hospital risk register.

The senior managers that we interviewed during our inspection demonstrated that they had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, and they told us that they felt well supported by their managers.

The provider had already identified that the leadership on Lower Court needed to improve. It was positive that when this was identified in December 2022 the director of clinical services for operations stepped down to provide immediate

frontline support to Lower Court to support staff to implement and embed the ward's action plan. At the time of our inspection, the ward manager was leaving their role. The provider had plans in place to improve the leadership on Lower Court ward. An experienced manager was due to step into the current ward manager vacancy, and the two temporary part-time consultant psychiatrists were to be replaced by a permanent consultant psychiatrist in March 2023. These posts had not yet been recruited into, so the ward relied on the leadership delivered by the director of clinical services for operations.

Leaders were visible in the service, approachable and accessible for patients and staff. Staff reported they could raise concerns with them.

Leadership development opportunities were available, including opportunities for staff below team manager level. For example, the provider supported several assistant psychologists to embark on further training such as cognitive behavioural training and integrated therapy.

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 had developed five principles for working with young people in their CAMHS service: nurture, expectations, respect, enabling and reflection.

Staff we spoke with understood that provider's vision and values. Senior managers and ward managers visibly demonstrated the values to provide the best possible care and treatment to patients.

Staff had the opportunity to contribute to discussions about the strategy for their service. For example, the hospital director had a monthly open-door hour where staff could drop in and discuss relevant matters. There was a senior management team visibility programme in place as part of the SMT initiative to ensure senior leader visibility on the wards.

Culture

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

Overall, staff that we spoke with felt positive and proud about working for the service and their team. Staff said the team were supportive of one another and they felt able to raise issues without fear of retribution. Some staff on Lower Court said that the high turnover of staff and high use of agency staff had impacted team morale and increased pressure on permanent staff members.

Staff knew how to use the whistle-blowing process. The wards had a whistle-blowing poster in the nursing office which detailed a whistleblowing helpline. The hospital had a whistle-blowing policy.

All staff that we spoke to said that the team worked well together and that the team was supportive. On the ward we observed good interactions between disciplines.

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

The provider recognised staff success within the service, for example, through staff awards.

Governance

Our findings from other key questions demonstrated that governance processes did not always operate effectively. For example, the provider's housekeeping procedures did not ensure all ward areas were effectively cleaned and there were no systems in place to ensure patient food had not expired in patient kitchens. There were lapses in recording of restraint, and food and fluid chart documentation. Not all staff were up to date with key mandatory training modules. The overall leadership of Lower Court had been identified as requiring improvement. Although there was a robust action plan in place it was still a work in progress.

The hospital director and senior management team were mostly aware of the areas where improvement needed to be made and were committed to improving care and treatment for patients. The provider's governance processes highlighted that Lower Court required significant improvement and senior management put an immediate action plan in place to support the performance of the ward and were aware that the plan needed to be embedded and sustained. Senior leaders met weekly to discuss progress of the action plan.

Where we raised new concerns with senior leaders during our inspection, they were responsive and put immediate actions in place to mitigate identified risks.

Since our last inspection in February 2022 on Lower Court, improvements had been made. Agency staff now had access to patient records and supervision, staff had access to regular staff meetings and debriefs following incidents, there was a clear care pathway in place to support admissions, and there were robust systems in place to learn from incidents. However, some governance processes required improvement, whilst we found up to date cleaning records for the wards, Lower Court was still visibly dusty in areas and there lacked systems to manage expired food in patient kitchens. Whilst there were plans in place to ensure staff compliance with mandatory training, some modules were still low. We also found gaps in recording of restraint and food and fluid charts.

The wards had regular team meetings and management meetings with clear agendas. This ensured that essential information, such as incidents, safeguarding and complaints where shared and discussed.

Senior managers, including ward managers attended regular meetings to ensure support safety and governance of the wards. For example, a daily 'flash' meeting where staffing, incidents and immediate safety topics were discussed, and a weekly patient safety meeting where incidents, team incident reviews / lessons learnt, complaints / concerns and policy updates were discussed.

Senior staff attended a specialist services business meeting once a month. This meeting included the therapy leads, ward managers from CAMHS and the adult NHS Ward, and the interim director of clinical services for CAMHS.

Senior management attended monthly clinical governance meetings. There was a clear agenda of what was discussed to ensure essential information was shared. For example, the risk register, serious incidents, staffing, safeguarding and audits were discussed and reviewed.

Requires Improvement

Child and adolescent mental health wards

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of patients. The hospital safeguarding leads raised concerns with the local authority. Staff worked closely with education staff from the attached school.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. There was a good action plan in place to support Lower Court. However, some areas of training had low completion rates which could affect patient care.

The hospital maintained a risk register, which included a full description of the risk and planned actions to reduce the risk. The managers could escalate concerns when required through the regular clinical governance meetings and daily 'flash' meetings.

Staff concerns matched those on the risk register. Leaders were aware of the main risks in relation to the service and they were providing and demonstrated a good understanding of how to improve performance. The hospital's risk register was reviewed at the monthly clinical governance meeting.

At the time of the inspection, the top six risks related to Lower Court requiring significant improvement, recent changes in senior management team, the use of 5-point risk assessments and a secure building, HR challenges, training compliance dropping due to gap in HR lead, and nursing vacancies.

When staff identified areas for improvement, they developed plans to address the concern. For example, the director of clinical services for operations was delivering a specific action plan to improve patient safety on Lower Court.

The hospital had a cross-site plan in place to ensure that 95% of staff were compliant with mandatory training modules by May 2023.

Information management

Staff engaged actively in local and national quality improvement activities.

The service used systems to collect data from wards 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 improve the quality of care.

Information governance systems included confidentiality of patient records. Staff stored confidential records securely using the provider's electronic record systems. When they used paper records, they stored them securely in the nursing office.

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.

The hospital made notifications to external bodies as needed, included statutory notifications to the Care Quality Commission.

Requires Improvement

Child and adolescent mental health wards

Engagement

Patients and staff were able to provide feedback to the service. However, carers were not always kept up to date with the work of the service their relatives received.

Staff and patients had access to up-to-date information about the work of the provider and the services they used.

For example, staff are kept up to date through the intranet and weekly emails from the hospital director. Patients are kept up to date by weekly community team meetings.

Some carers we spoke with did not feel that they were kept up to date with the work of the provider and services their relatives received. There was a feedback form in place for carers to offer feedback ahead of relative's ward rounds, but these were not being used effectively. One carer told us that they completed a feedback form and emailed it to the ward's email address, however, staff did not use the feedback in the ward round as no one was monitoring the ward email inbox due to the ward clerk vacancy. We highlighted this to managers during the inspection, who told us that the consultant psychiatrist would monitor the ward inbox until a locum ward clerk joined the team the week following our inspection.

The hospital recognised that they needed to improve carer engagement and the therapy lead for CAMHS and specialist service was in the process of setting up an online carer's group.

At the time of our inspection, the provider was engaged with the South London Partnership (SLP). The SLP were monitoring Lower Court and providing support particularly around safeguarding concerns. The director of clinical services for operations met with the SLP on a regular basis.

Learning, continuous improvement and innovation

CAMHS staff shared and learned good practice with the other CAMHS wards across the provider. The provider's CAMHS service line lead sent a CAMHS bulletin to the ward to continue shared learning specific to CAMHS. Staff had the opportunity to attend the provider's monthly network call.

At the time of the inspection, Lower Court had not participated in accreditation schemes such as the Royal College of Psychiatrists quality network in CAMHS (QNIC) as they did not feel they were ready for it. They had an action plan in place to improve the ward's quality and performance to enable them to participate in the peer review visit.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that ligature risks and blind spots are adequately mitigated on Garden Wing and Upper Court. All staff should be aware of what a ligature point is, and where they are located on the wards. Regulation 12 (2) (b) The service must ensure that where wards use CCTV, this is done in a clear and consistent way to support the safe care of patients. Regulation 12 (2) (a) (b) The service must ensure that persons providing care and treatment to children and young people have the competence, skills and experience to do so safely. Regulation 12 (1) (2) (a) (c)

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure that governance processes operate effectively to identify any improvements required for the acute wards. Regulation 17 (1) (2) (a) The service must ensure that systems or processes are established to ensure ward areas are clean and well-maintained, including systems to ensure there is a plan in place to manage expired food in patient kitchens. Regulation 17 (1) (2) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure staff complete their mandatory training, in particular restraint intervention, safeguarding and immediate life support training, so they can deliver their roles safely. Regulation 18 (2) (a)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure they review the blanket restriction around arrangements for informal patient leave and consider more appropriate processes to ensure patients rights are upheld at all times. Regulation 9 (3) (a) (b) The service must ensure Upper Court has information on advocacy services available to patients, and signs explaining information patient rights. Regulation 9 (1) (2) (b) The service must ensure that all patients on the acute wards are involved in decisions about their care, and have a copy of their care plan. The service must ensure that ward community meetings take place regularly. Regulation 9 (3) (b) The service on Lower Court and Richmond Court must ensure staff inform and involve families and carers appropriately, and provide them with support where needed. Reg 9 (3) (g)