Alternative Futures Group Limited

Fir Trees Independent Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The hospital environment was safe and clean.
- Staff assessed and managed risk well and stored medication safely. They minimised the use of restrictive practices.
- 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 cared for in a mental health rehabilitation hospital and this was done in line with national guidance about best practice.
- The teams included or had access to the full range of specialists required to meet the needs of patients on the wards including occupational therapy and psychology.
- Managers ensured that staff received training, supervision, and appraisal.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Carers confirmed they were actively involved in care decisions.
- Patients were positive about the care they received from staff and felt actively involved in care decisions. All the patients interviewed felt safe. Carers were also highly satisfied with the service.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. There were records of patients being discharge back into the community.
- The service worked to a recognised model of mental health rehabilitation. Staff morale was high. The hospital was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- Despite most records being electronic staff had continued to create large paper records which were not always as up to date as the electronic record. This meant that staff did not always have access to the most up to date information about patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Good 	Our rating of this service stayed the same. We rated it as good because: • The service provided safe care. The hospital environment was safe and clean. The hospital had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. • 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 cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The staff worked well together as a multidisciplinary team and with those outside the hospital who would have a role in providing aftercare, for example local community mental health teams. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. • Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. • Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

- The service worked to a recognised model of mental health rehabilitation. It was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- Despite most records being electronic staff had continued to create large paper records which were not always as up to date as the electronic record. This meant that staff did not always have access to the most up to date information about patients.

Summary of findings

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Summary of this inspection

Background to Fir Trees Independent Hospital

Fir Trees provides services for male and female patients with mental health needs who require mental health rehabilitation. It is managed by the Alternative Futures Group which is a registered charity who have several other mental health hospitals and community services within the northwest of England.

Fir Trees is a 14-bed hospital and provides rehabilitation to both patients detained under the Mental Health Act and informal patients. It provides community-based inpatient mental health rehabilitation.

There was a registered manager in post at the time of our inspection, a controlled drugs accountable officer and a nominated individual for this location.

The service is registered to provide the following regulated activities:

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

• treatment of disease, disorder and injury, and

• diagnostic and screening procedures.

The local clinical commissioning group block purchase all the beds and only those within the Wigan area can receive treatment.

Fir Trees was last inspected in February 2018. On that inspection, we rated Fir Trees as good overall. We rated effective as requires improvement and the other 4 key questions (safe, caring, responsive and well-led) as good.

The last report stated what action the provider should take to improve. These were as follows: -

• There were no psychologists working into the service. We did not find any evidence of psychological interventions being provided to the patients as part of their rehabilitation and recovery care pathway.

• There was no evidence to show if patients had been given copies of their care plans or if they had refused a copy.

• Section 17 leave forms were not fully completed. The outcome of leave was not being recorded.

Staff ensured ratings were displayed in a prominent place as required. The provider has a duty to ensure CQC ratings are displayed appropriately so patients, visitors and the public can easily see the hospital's ratings. On this inspection, we found that the current ratings were displayed on the provider's website. The current ratings were also displayed near the hospital's reception area.

What people who use the service say

We interviewed all eleven patients and 5 carers, all of whom were positive about the politeness and respectfulness of staff. They spoke positively about staff who they worked with. Staff were described as supportive, kind, respectful and caring.

Summary of this inspection

All carers described the hospital as the best they had been involved with.

However, after the inspection we received a comment from a patient who raised concerns regarding the lack of activity and criticised the attitude of one staff member.

How we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

To fully understand the experience of people who use services, we always ask the following 5 questions of every service and provider:

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

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

During the announced inspection visit, the inspection team:

- visited the hospital and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with 11 patients and 5 relatives
- spoke with the registered manager
- spoke with 4 other staff members: including nurses, support workers and an occupational therapist
- attended and observed 1 community meeting
- looked at 5 care and treatment records of patients
- carried out a specific check of the medication management at the hospital
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

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

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that paper records if in use, contain the most up to date information about the patients.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Good

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

Is the service safe?

Good

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

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We examined a recent fire risk assessment which had identified ill-fitting fire doors. We saw that these doors had been repaired.

Staff could observe patients in the main parts of the ward. Fir Trees building is hexagon shaped with corridors circling an inner courtyard which contained a covered smoking area. There were 14 en-suite bedrooms of which 8 rooms also had kitchenettes. Where there were blind spots, parabolic mirrors were used to mitigate.

Male and female bedrooms were separated in compliance with the Department of Health's guidance on same sex accommodation. Patients did not have to pass through a living area occupied by the opposite sex. There was a female only lounge. 2 of the 8 bedsits with kitchenettes were separated from the circular corridor by a door making them suitable for female only occupation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service only admitted patients who had been assessed as low risk of self-harm. Fir Trees had 2 bedrooms with anti-ligature bathroom fittings and anti-barricade doors. This enabled staff to manage patients in an appropriate environment if their risk of self-harm increased following admission.

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

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff followed infection control policy, including handwashing. Hand sanitiser was available on entry/exit to wards.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning and catering services were provided by external contractors. However, they carried out the necessary statutory health and safety checks and assessments. The hospital had an auditing process to ensure the external contractors completed those assessments and checks.

Staff followed infection control policy, including handwashing.

Fir Trees did not have a seclusion facility. Staff would not admit patients if seclusion was likely as part of an individual management plan.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Medicine cupboards were not over-stocked, and medicines were in date. Emergency drugs were available and within date. Oxygen and resuscitation equipment, including defibrillators, were all maintained and recently checked.

Staff checked, maintained, and cleaned equipment. The clinic room was clean, tidy, and equipment requiring calibration had stickers to show when it was last checked. Sharps boxes were all in date, and not overly full.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Overall, there were 7 registered nurses and 11 support workers. On each day shift there was 1 registered nursing staff and 2 support workers. These were supported by the registered manager, a senior nurse practitioner, occupational therapist and clerical support. On each nightshift there was 1 registered nursing staff and 2 support workers.

The service had reducing vacancy rates. The service had seen reducing vacancies rates from 15.8% in April 2023 to being slightly overstaffed at the time of inspection.

The service had low rates of bank staff. We examined the staff rota, out of 58 days we examined the same bank staff had covered 11 shifts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The hospital regularly used 3 bank nurses and 2 support workers who knew the hospital well and provided consistent nursing care.

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

The service had reducing turnover rates. From April 2023 the hospital had reduced the number of vacancies from 3 to being an additional 0.5% over strength in December 2023.

Managers supported staff who needed time off for ill health.

Levels of sickness were low. From June 2023 to November 2023 the average sickness rate was 2.89%

Long stay or rehabilitation mental health wards for working age adults

Good

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The registered manager could adjust staffing levels according to the needs of the clients. Staffing levels were increased in line with client's needs, such as escorted leave, attendance at other hospitals or increased observational levels.

Patients had regular one- to-one sessions with their named nurse. We saw these regular sessions were well recorded in clients' notes.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Nursing staff were visible on the ward providing care and treatment to patients. Staff and patients told us leave or activities were never cancelled. The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

There were appropriate handovers between the different shifts so relevant information was shared.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. A consultant psychiatrist attended the service once a week. They were also responsible for completing a physical examination of patients upon admission. During out of hours and when the psychiatrist was on leave or away, psychiatric input came from the doctor on call within the providers pool of psychiatrists. These arrangements were reported to work well.

If there was a medical emergency, the emergency services would be called.

Patients were also registered with the local GP who provided medical input for physical health conditions, including completing comprehensive annual physical health reviews. We were told that communication with the GP was good.

Managers could call locums when they needed additional medical cover and managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. All staff at Fir Trees had completed training as part of their induction and ongoing refresher training. We saw training levels at nearly 100% with those due to attend refresher courses booked in advance.

Some of the main topics included in this training course were: -

- intensive life support and first aid training
- safeguarding, levels 1,2 and 3
- health and safety
- moving and handling
- recovery star

- therapeutic management of violence and aggression
- positive behaviour support
- slavery and human trafficking.

The mandatory training programme was comprehensive and met the needs of patients and staff. There was a mixture of face-to-face training and online. There were several online courses that covered autism awareness and other conditions such as schizophrenia, depression, bi-polar and anxiety.

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

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission, using a recognised tool, we did see that staff regularly reviewed assessments, including after any incident. We looked at 5 patient's care records. These contained an up-to-date and detailed risk assessment. On 1 record out of 5 that we looked at there was no individual patient risk assessment completed by the hospital. The patient had been admitted 7 days previously and there was a risk assessment from the community mental health team. An interim care plan completed by the hospital did address what they should do in the event of an incident.

Staff used a recognised risk assessment tool. The hospital used the Salford Tool for Assessment of Risk (STAR). The hospital had an electronic care record system which recorded all assessments, however they also printed off records and each patient had a lever arch file containing documents printed off. We found that paper records were not always as up to date with the computer systems assessments. This meant that staff could potentially miss new information if they referred to the paper records.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff could explain the risks presented by each patient. Staff were able to explain how they would mitigate specific risks, such as by the risk assessment of items allowed onto the ward.

Staff identified and responded to any changes in risks to, or posed by, patients. Risk assessments were updated after incidents and staff knew patients well and responded if patients' presentation changed.

Staff followed procedures to minimise risks where they could not easily observe patients. Admission policies reduced the risk of patients causing harm to others or themselves. Staff conducted observations and completed ligature surveys.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff conducted searches only, when necessary, in response to risk of patients having contraband items.

Long stay or rehabilitation mental health wards for working age adults

Good

Use of restrictive interventions

Levels of restrictive interventions were low. Most patients were detained under the Mental Health Act, with many having unescorted leave. Each patient was individually assessed to ensure any restrictions were kept to a minimum. These assessment plans included assessing restrictions related to medication, equipment, the environment and any other restrictions in place. Where individual restrictions were in place, these were reviewed by the team supporting the patient.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There were no blanket restrictions in place. The front door was locked but all the patients had access to the grounds and gardens throughout the day. There were notices by the front door informing informal patients and patients with unlimited unescorted leave of their right to leave and that they just needed to ask staff to open the door.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Restraint was not regularly used at Fir Trees as a mental health rehabilitation ward. In the last 12 months, there had been no recorded incident of restraint. Patients and staff told us that they knew each other well. Patients told us that when they became agitated or distressed staff were skilled at supporting them.

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

Fir Trees did not use rapid tranquilisation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff could describe the safeguarding reporting process in the hospital. Staff described that they reported any incidents to the clinical lead nurse or registered manager.

Staff kept up to date with their safeguarding training. Staff training was at 100% with staff receiving training up to level 3 for adults, level 1 for children and managers received additional training in the management of safeguarding incidents.

Staff could give clear examples of how to protect patients from harassment and discrimination. They described an incident of sexual concern, and staff could provide details of the incident and how they had protected the victim from further incidents.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. There had been 3 safeguarding incidents, 1 of sexual behaviour, 1 involved financial abuse and the 3rd was an injury to a patient being nursed elsewhere at that time.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had several designated safeguard leads. Staff described looking out for vulnerabilities including domestic violence and neglect either for or against the client. Staff reported good links with the local authority and felt able to ring colleagues for advice if needed.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers took part in serious case reviews and made changes based on the outcomes. Alternative Futures had its own safeguarding policy and procedure. The policy guided staff to follow the local safeguarding procedures.

Staff access to essential information

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

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

Although the service used a combination of electronic and paper records, risk assessments were still recorded on paper, all other records were electronic. Staff kept paper files on patients by printing all the electronic records they created. We found that not all the paper files created by staff were up to date. We were told that these files were back up files and not routinely used by staff.

Records were stored securely. Files were kept within the nurse's station.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service had a paper system for prescribing and administering medicines. Staff stored and managed all medicines and prescribing documents safely. Pharmacy staff attended at regular intervals to ensure stock was managed appropriately and available when needed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists attended when required and were available to meet with patients to discuss and provide information around medicines. This included leaflets in easy read formats and different languages.

Staff completed medicines records accurately and kept them up to date. The medicine charts we reviewed were well maintained, with no discrepancies. We saw these reflected patient's allergies.

Staff stored and managed all medicines and prescribing documents safely. We saw evidence of the checks carried out by the community pharmacist, and clinic checks conducted during the inspection found that medicine was being stored safely, all were within date, and cupboards were not overstocked.

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

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients' medicine was monitored at review by the responsible clinician, as well as the community pharmacists who attended the service.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We also saw patients that attended a local clozapine clinic were monitored by staff and the results well documented.

Long stay or rehabilitation mental health wards for working age adults

Good

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong.

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

Staff knew what incidents to report and how to report them. There were 75 incidents reported for the 12 months from 1 January 2023. 18 of these incidents related to minor medication issues or discrepancies where patients were self-medicating.

Staff reported serious incidents clearly and in line with the providers policy. There had been no serious incidents within the last 12 months.

The service had no never events. A 'never event' is a wholly preventable serious incident that should not happen if preventative measures are in place. In mental health services, the relevant never events within hospital settings were actual or attempted suicide of a person due to the failure to install functional collapsible shower or curtain rails and falling from an unrestricted window.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers were aware of their responsibilities in relation to duty of candour which required staff to be open and offer an apology when an incident occurred resulting in serious harm. There had been no notifiable events which met the threshold of moderate or severe harm under duty of candour in the last 12 months.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw that managers had investigated incidents and that patients had received feedback from those investigations.

Staff met to discuss the feedback and look at improvements to patient care. We saw incidents had been discussed within the hospital and these discussions had been recorded in team meeting agendas and minutes.

There was evidence that changes had been made as a result of feedback. Managers could provide evidence of changes and these related to individual responses to a patients needs after an incident.

Is the service effective?

Good

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

Assessment of needs and planning of care

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients at Fir Trees had the same commissioner of services, therefore they had been assessed by the same commissioning service prior to admission. On all 6 patients' files we looked at, we saw a detailed mental health and rehabilitation assessment and associated care plan for all except 1 recent admission who had not yet had a full risk assessment completed by the hospital. They did have a comprehensive risk assessment completed just prior to admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. All 6 patients physical health had been assessed and all 6 had physical health care plans. We saw that once patients had been admitted they had regular physical health checks. All patients were registered with the local GP.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. This followed the format of a recognised recovery-based assessment tool (the mental health recovery star). This tool assessed and provided guidance on recovery-based support to people with mental health needs. The mental health recovery star was a collaborative tool and allowed staff and patients to work together to produce an overarching care plan that looked at their holistic needs. We saw these were comprehensive for all 6 patents.

Staff regularly reviewed and updated care plans when patients' needs changed. We saw that care plans were regularly reviewed through the multi-disciplinary team meetings and after any incidents.

Care plans were personalised, holistic and recovery orientated. Care plans were individualised, one reflected a patients need to have certain items with them, another reflected that individual's abstinence plan.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. The electronic record system allowed for more than one care plan to be prepared, and we saw that the care plans were comprehensive and being shared with patients. Each care plan fed into a different aspect of patient care, allowing a holistic approach to nursing.

For example, we saw patients having been assessed for their road sense. Patients were supported to access social, cultural and leisure activities, education and vocational resources to help aid their recovery. We saw that patients had been fishing and had clubs to access the local golf range. There were also football training and a team which patients could play for in a diversity league. There were close ties to the local professional football club.

Alternative futures had a "butterfly moment" dashboard which recorded "A story that describes a positive moment where someone we support has achieved something important in their day-to-day life or achieved a personal goal." This allowed staff and patients to record significant moments within their care plans.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g., NICE) The psychiatrist had commenced clozapine as a medicine to patients to minimise symptoms of their mental health. This had required staff training and understanding of the issues involved with those patients attending a local clozapine clinic.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff identified patients' physical health needs and recorded them in their care plans. Nurses were using standardised tools to carry out an assessment of the patient to understand their physical health needs, including the effects and side effects of medication for mental disorder using recognised tools such as the LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) and NEWS2 (National Early Warning Score 2) (National Early Warning System) tools.

Staff made sure patients had access to physical health care, including specialists as required. Patients were encouraged to visit and speak to the GP about any physical health concerns. The GP carried out annual physical health checks. We saw from records that patient's pulse, pulse oximetry, respiration, weight BMI (Body Mass Index), temperature, and ECG were taken regularly.

We saw that patients had accessed dentists and opticians.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients told us that any religious or dietary needs were met with halal food and vegan diets supported.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. While patients were allowed to smoke within the ground of the hospital courtyard the hospital did have a cessation policy and was attempting to encourage patients to stop smoking by offering a number of alternatives.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. As well as LUNSERS and NEWS2 the hospital also used Salford Tool for Assessment of Risk, a mental capacity assessment tool as well as the recovery star.

Staff used technology to support patients. Patients had access to mobiles phones and laptops.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. There were regular audits of care records, infection control, medicines, Mental Health Act paperwork and physical health assessments. All audits were discussed at managers meetings and we saw examples where staff had received development when issues had been identified.

Managers used results from audits to make improvements. We saw that managers used these audits to inform discussion in team meetings and the outcome of those discussions resulted in changes to practice.

Skilled staff to deliver care.

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

The service had access to a full range of specialists to meet the needs of the patients. Patients received multi-disciplinary input from a psychiatrist, a psychologist, nurses, support workers and an occupational therapist. The service had access to a speech and language therapist when required.

The psychologist was on a retainer and attended to deliver cognitive behavioural therapies, other therapies and clinical psychology input as required. Patients assessed and had access to talking therapy and through the full-time occupational therapist other treatments to aid their recovery in line with best practice.

Long stay or rehabilitation mental health wards for working age adults

Good

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Many of the patients had been at Fir Trees for nearly a year, staff had a good understanding of the patients needs including how they managed their relationships with their families. Staff/patient conversations were positive, and it was clear they all worked well together and enjoyed being together.

Managers gave each new member of staff a full induction to the service before they started work. The induction included mandatory training and shadowing existing staff.

Managers supported staff through regular, constructive appraisals of their work. All staff received an annual supervision meeting and assessment. There were also monthly case supervision meetings where staff discuss a case together so they could learn from each other.

Managers supported permanent medical staff to develop through yearly, constructive appraisals and supervision of their work. Medical staff received appraisal and supervision from within the Alternative Futures management structure.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. There were regular team meetings with a set agenda which covered hospital performance and provided staff with information about new working practices or individual changes to care plans for patients.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw all staff had undertaken additional training covering several mental health conditions such as autism, schizophrenia and anxiety.

Managers made sure staff received any specialist training for their role. This included all staff receiving training on clozapine medication.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers had managed staff through absence management processes to support them after periods of absence.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary team meetings occurred every week with each patient usually being discussed at least once per month. We were assured that should a patient need to see the psychiatrist they would be able to do so even if they were not due to attend the multidisciplinary meeting that day.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Patient care, treatment and risk assessments were reviewed on handover with any changes to patients' behaviour or care noted.

Ward teams had effective working relationships with other teams in the organisation. Staff could access other professionals for patients via referral through the GP, for example dietitian or speech and language therapy.

Long stay or rehabilitation mental health wards for working age adults

Good

Ward teams had effective working relationships with external teams and organisations. All patient's care was commissioned by the same service. This meant that the hospital and external care co-ordinators had a close relationship. The manager attended regular commissioning meetings where potential discharges and admissions were discussed within the wider mental health care provision for that area.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff had received training in the Mental Health Act. Staff were knowledgeable when asked and they confirmed they had completed this training as part of their mandatory training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. There was a member of staff who attended weekly to check that the hospital was compliant with its responsibilities and all staff were able to identify who their mental act administrator was.

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 confirmed these were available for them on the hospital's intranet.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients had access to a local advocacy service, and we saw posters identifying the service to patients. Patients also confirmed they had spoken to the advocate when they needed to do so.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Several patients had significant periods of unescorted leave and the hospital was busy with patients leaving and returning from section 17 leave. We saw no delays in patients taking section 17 leave that needed escorting and section 17 decisions were well recorded with clear conditions.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of this when we looked at consent documentation and medicines records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. The original Mental Health Act paperwork for each patient was kept in legal files in a locked cabinet in the manager's office. Copied detention papers were available to staff.

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

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

Long stay or rehabilitation mental health wards for working age adults

Good

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We looked at an audit that confirmed this.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the 5 principles. The staff we spoke with demonstrated a good understanding of the application of the Act in their day-to-day work with patients.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff confirmed these were available for them on the hospital's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Consent to treatment and a patient's capacity were clearly recorded in all patient records.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. The hospital had a best interest checklist form which covered the legal requirements when looking at best interests. Members of the multidisciplinary team could explain the process and their responsibilities when assessing capacity.

Staff were aware of the processes to obtain a Deprivation of Liberty Safeguards order. There were no Deprivation of Liberty Safeguards applications made in the last 12 months. There were no patients subject to the Deprivation of Liberty Safeguards at the time of our inspection. Staff were able to describe when the safeguards may be used.

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

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Long stay or rehabilitation mental health wards for working age adults

Good

Staff were discreet, respectful, and responsive when caring for patients. We interviewed all eleven patients and 5 carers, all of whom were positive about the politeness and respectfulness of staff. They spoke positively about staff who they worked with. Staff were described as supportive, kind, respectful and caring.

However, after the inspection we received a comment from a patient who raised concerns regarding the lack of activity and criticised the attitude of one staff member.

Staff gave patients help, emotional support and advice when they needed it. One carer described the named nurse as "inspirational" and had transformed their son who was now nearing discharge. They had taken him hiking, which the patient had done from an early age with their family, to aid his recovery.

Staff supported patients to understand and manage their own care treatment or condition. One carer told us that their son had asked to change medication as he thought it was giving him anxiety. The psychiatrist listened to his needs and expressed some concern about changing the medication but agreed to do so. The parent believed this had made a big improvement to their son's health.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us they had no difficulty getting support both within the hospital and with other organisations such as housing.

Patients said staff treated them well and behaved kindly. One carer described how their loved one could quickly become agitated and potentially self-harm. They described how staff quickly recognised this and would change their section 17 leave to escorted while they worked to help stabilise their emotions.

Staff understood and respected the individual needs of each patient. All carers thought the hospital had been transformational in their loved one's recovery. Each of them was able to provide examples where they believed the staff had helped the individual needs.

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

Staff followed policy to keep patient information confidential. There had been no patient data breach incidents at the hospital.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Due to the close relationship with commissioner's patients often visited Fir Trees before admission. Assessments were made by the registered manager and clinical lead nurse. Staff also completed an admission check list when admitting a patient.

Staff involved patients and gave them access to their care planning and risk assessments. Care records showed that patients were always offered copies of care plans, and risk assessments showed evidence of patient involvement. Recovery stars completed by the patients were included in care plans.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). All the patients and carers we spoke to could understand their treatments and their goals to move on.

Staff involved patients in decisions about the service, when appropriate, and they could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held, and we saw minutes from meetings on the notice board. These showed consideration of patients' thoughts and outlined attempts to include patients on improving the service. There were also daily morning meetings which included the patients where they could suggest activities for the day.

Staff supported patients to make decisions on their care. Patients were listened to when they expressed views on their care, these involved changing medications our individualising activities.

Staff made sure patients could access advocacy services. Patients told us they were aware of advocacy services, and they did use the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. All 5 carers told us they were extremely pleased with the care their loved ones were receiving. They all felt involved and reassured. One told us that their loved one had developed so much that they had rung them to say they did not need their support at a meeting with a social worker.

Staff helped families to give feedback on the service. All carers felt they were encouraged to visit the hospital and to attend meetings to discuss their loved one's development and treatment options. All felt that their views and concerns were listened too.

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

Is the service responsive?

Good

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

Access and discharge

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

The hospital had a 14-bed capacity and at the time of our inspection there were eleven patients. Managers told us they never operated at capacity and had only done so once when another hospital had been flooded.

Long stay or rehabilitation mental health wards for working age adults

Good

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 the current patients in 2023 was 504 days. There were 2 patients who were still waiting for discharge after 2 years. These patients had been admitted with severe needs and long-term rehabilitation had been expected.

The service had no/low out-of-area placements. All the current patients came from the local area. All of the beds at Fir Trees were block purchased and paid for by the local clinical commissioning group.

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

When patients went on leave there was always a bed available when they returned. Since January 2023 there had been 6 discharges. 4 either moved on to their tenancy or returned to the family home, with 2 transferring back to hospital.

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

Patients were moved during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. 2 patients were transferred back to an acute mental health ward setting in the 12 months prior to our inspection.

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

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. The hospital had an agreement with local commissioners that any patient who deteriorated requiring secure accommodation would be transferred that day or the day afterwards. On the 2 occasions this was required we saw that this had been complied with.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Managers did monitor delayed discharges and were firmly imbedded in the local commissioning processes to ensure discharge. However, some discharges were delayed beyond the control of the hospital due to the lack of appropriate social housing.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients care and discharge was discussed in weekly multidisciplinary meetings with those involved in that decision present to support transitions of care.

All the patients we spoke with understood what their discharge plan was and could explain what they were expecting when discharged.

Staff supported patients when they were referred or transferred between services. Many former patients were still in touch with the hospital through the football team, and the service was well connected with the mental community of Wigan so they were aware of previous patients' development and those who may be lapsing.

Long stay or rehabilitation mental health wards for working age adults

Good

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise. Patients had access to their rooms 24 hours a day.

Patients had a secure place to store personal possessions. Each room had a secure locker as well as separate lockable medicines storage for patients who had been assessed for self-medicating.

Staff used a full range of rooms and equipment to support treatment and care. This included a clinic room, a large lounge, dining room, kitchens, quiet rooms and a games room containing a pool table and darts board.

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

Patients could make phone calls in private. Patients had access to their own mobile phones but for those that did not a telephone was available.

The service had an outside space that patients could access easily. There was a garden around the whole perimeter of the hospital allowing patients outdoor space. There was also a large outdoor internal courtyard which patients gathered in. Smoking was allowed within this area.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients in the self-contained bedsits had a kitchenette where they could make meals and hot drinks.

The service offered a variety of good quality food. Catering services had been contracted out to another company. These were supplied frozen and then reheated as per the menu. Patients were offered healthy alternatives such as salads or jacket potatoes. Patients told us that the food was good and catering staff were popular.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients were supported to improve their daily skills with the occupational therapist offering a wide choice of activities including making meals in the kitchen, craft, and reflective classes.

Staff helped patients to stay in contact with families and carers. All the carers we spoke with were positive about the amount of communication they got from the hospital and if they rang to ask how a patient was that day, they always got a full briefing about that patient. Patients were encouraged to use section 17 leave to visit carers.

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

Meeting the needs of all people who use the service.

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was an adapted bedroom and bathroom to support those with mobility needs. Staff told us that easy read information about medication and some other topics were available and were printed off for patients when required.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were notice boards and leaflet racks, which included a range of information. This included information about the hospital, treatments, medication, advocacy and complaints.

The service had information leaflets available in languages spoken by the patients and local community. Managers assured us, staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. If patients required a specialist diet such as halal, kosher, vegetarian of vegan food to meet their specific needs this was ordered as required.

Patients had access to spiritual, religious and cultural support. Patients told us that, if they wanted, they could access religious or cultural support. Staff told us this could be facilitated.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers we spoke with understood their right to complain and felt confident that managers would investigate complaints fully. Most had raised a small issue verbally and had always felt that managers had responded quickly to address those verbal concerns.

The service clearly displayed information about how to raise a concern in patient areas. There were noticeboards with signs outlining the complaint process for patients, as well as in the communal areas where visitors might arrive.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with understood their role in supporting patients' rights to complain.

Managers investigated complaints and identified themes. There had been no formal complaints made about this hospital from 1st January 2023.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Most complaints were raised individually or within community meetings. We saw that managers had acted upon complaints within community minutes.

The service used compliments to learn, celebrate success and improve the quality of care. There had been 2 compliments raised in the previous 12 months, one from a student nurse who had enjoyed their placement and one from the father of a patient saying this had been the best hospital his son had been admitted too.

Long stay or rehabilitation mental health wards for working age adults

Good

Is the service well-led?

Good

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

Leadership

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

Staff felt supported and the team worked well together. The registered manager had worked at the hospital for several years had very good clinical oversight of the hospital while also being approachable to patients.

They were supported by a clinical lead nurse who also had a good clinical overview of the hospital.

Both had a clear understanding of the services they managed. They could explain clearly how the team were working to provide high quality care. There was a positive staff culture in the service.

Vision and strategy

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

Alternative Futures had the following vision and mission: 'A world where people control their lives. Together with our people and partners we will unlock skills, gifts, and talents to support everyone's right to choose and achieve their aspirations.'

They had the following values:

- We are one.
- We raise the bar.
- Every person matters.
- We make a positive difference.
- We take ownership.

The values were developed through a number of listening sessions for staff.

Staff could talk about the values of the service and were committed to providing the best care they could.

Long stay or rehabilitation mental health wards for working age adults

Good

Culture

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.

All staff we spoke with said they felt supported and valued at the hospital, with both management and staff saying they felt the staff team were happy.

There were no reports of bullying or harassment at the hospital, and all staff we spoke to knew how to use the whistleblowing process. All staff told us that they felt they could raise concerns to management about the service without fear of retribution.

Governance

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

The registered manager had access to a computerised management system which assisted them to understand not only their hospitals performance but how they were performing against similar hospitals. The system created actions required by registered managers to ensure good quality care to patients. It included information on incidents, safeguarding concerns, complaints and compliments.

This ensured there were systems and procedures in place to keep the hospital safe and clean, that there were enough staff, that staff were trained and supervised, that clients were assessed and treated well, and that staff adhered to the Mental Capacity Act.

Processes ensured that clients risks were managed and that successful discharge from treatment were planned. Regular meetings were in place to review and investigate incidents and structured to allow regular feedback to staff.

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

There was an annual audit plan, a hospital risk register, and a business continuity plan. Systems and tools, such as staffing levels and the business continuity plan, were reviewed and tested to ensure they continued to reflect the service.

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

Managers regularly audited patient records to ensure that risk assessments and management plans were up to date. The quality-of-care plans was regularly reviewed, and managers worked closely with staff to make improvements in the quality-of-care plans.

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

There were quarterly governance meetings where policies and procedures and audit outcomes were discussed and tracked.

Long stay or rehabilitation mental health wards for working age adults

Good

Management of risk, issues and performance

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

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

The hospital had a contract in place with commissioners and had good links with the local public health community. The contract contained key performance indicators which were regularly reviewed.

Staff maintained and had access to the risk register at a service level. Staff felt able to escalate concerns when required to the manager who either dealt with them locally or escalated if needed. Staff were able to submit items to the provider's risk register which was accessible online.

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

Information management

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

The hospital used systems to collect data which were not onerous for frontline staff.

Staff had access to the equipment and information technology needed to do their work. They used technology to update records, which meant current information was always accessible.

The hospital managed information via an electronic dashboard, which held a range of information, measuring performance and this was updated regularly.

Using the dashboard, the information could be evaluated in total across the hospital and any issues noted.

Staff were committed to sharing information so that choices and decisions were supported.

Information governance systems included confidentiality of patients' records.

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

Staff made notifications to external bodies as needed.

Engagement

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

Managers were meeting regularly with the local clinical commissioning group who oversaw the quality and safety of the service as well as the admission and discharge pathway.

Long stay or rehabilitation mental health wards for working age adults

Good

Other professionals from the local mental health community regularly attended the multidisciplinary meetings.

Learning, continuous improvement and innovation

Fir trees hospital was working with the Quality Network for Mental Health Rehabilitation Services through the Royal College of Psychiatrists to meet the standards for Accreditation to the Inpatient Mental Health Services for Rehabilitation (AIMS).