Alternative Futures Group Limited Millbrook

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Outstanding
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We rated Millbrook Independent Hospital as good because:

- The ward was clean, tidy and well maintained. The clinic room was fully equipped and emergency equipment was checked regularly. Staff were aware of how to report incidents and did so via the online incident reporting system. The ward complied with guidance on same sex accommodation by having single ensuite bedrooms and a designated female lounge area. There were good medicines management procedures for recording, dispensing and storing of medication. Staff were aware of the duty of candour and their responsibilities surrounding this.
- Care plans were holistic, recovery focused and included the views of the patient. All patients had a physical health check on admission and there was evidence of ongoing physical health monitoring. There was evidence that National Institute for Health and Care Excellence guidance was being followed in relation to prescribing of medication and there was a range of psychological therapies on offer to patients. Clinical staff participated in a wide range of clinical audit, including medications, mental health act and care records. All staff had received an appraisal in the last twelve months. The mandatory training rate was 86%. This was above the Alternative Futures Group target of 80%
- We saw positive interactions between staff and patient. All patients we spoke with told us they were treated in a dignified, respectful and caring manner. The staff we spoke with knew the patients well and this was reflected in the care plans of the patients. Patients all had a copy of their care plan if they wanted one and they were fully involved in developing them. There were weekly community meetings where patients were given the opportunity to give feedback on the ward. Patients told us they were encouraged to join in with activities that were available in the local community
- The service was a good example of social inclusion and there was a big emphasis on patients engaging in activities in the local community. This included a college course called “back on track”, which consisted of short six week courses on English and maths
- the service was discharge orientated, discharges were well planned and happened at an appopriate time for that person. There was a full range of rooms to support care and treatment of the patients. Patients had the facilities to make a phone call in private. There was a big emphasis on patients accessing local groups for activities. However, there was also a wide range of activities available on the ward seven days a week including evenings. Staff and patients were able to discuss any issues in community meetings and staff meetings. Information leaflets were available in a range of languages if required. Patients had access to an independent mental health advocate who visited the ward on a weekly basis. Staff were aware of the organisation’s vision and values and used them as a basis for their work with patients’. These were displayed in the communal areas.

However:

- not all staff had received quarterly supervision as per the managing performance policy
- there was no agreement in place with the advocacy service for the provision of a generic advocacy for informal patients

Summary of findings

- the section 17 leave file contained duplicate copies of section 17 leave authorisation and old leave forms that had not been struck through. This made it difficult to establish exactly what leave had been granted for some patients
- in some of the files examined there was no evidence of the approved mental health professional report completed at the point of detention
- Sickness levels were at 9.5%

Summary of findings

Contents

Good

Millbrook Hospital

Services we looked at

- Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Alternative Futures Group Limited Millbrook

Millbrook Hospital is run by Alternatives Futures Group Limited. Alternative Futures Group Limited provide care and rehabilitation through their recovery and treatments centres for people with learning disabilities, physical disabilities ,mental health problems, substance misuse issues, complex care, autism, dementia and young people in transition. Alternative Futures Group Limited has a number of specialist hospitals spread across the North West of England.

Millbrook is an independent hospital owned by the Alternative Futures Group Ltd. It was purpose built and opened 12 years ago. It provides care and treatment for men and women with mental health needs, some of whom are detained under the Mental Health Act 1983.

The hospital has 12 beds each with an ensuite shower and toilet. Four of the rooms have cooking facilities. The hospital is located in a residential area of Wythenshawe, south of Manchester.

Millbrook Hospital has been registered with the CQC since 21 December 2010. There have been four inspections carried out at Millbrook Independent Hospital. The most recent inspection took place on 19 December 2013. As of 24 January 2014, Millbrook Independent Hospital is currently deemed compliant.

There was an interim manager in place at the time of our inspection.

Our inspection team

Team leader: Kirsty Dixon, CQC Inspector

The team that inspected Millbrook Hospital comprised of three CQC inspectors, one CQC Mental Health Act reviewer and an Expert by Experience (someone who has experience of using mental health services).

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service and three carers. We also collected feedback from six patients using comment cards
- spoke with the acting manager and the clinical nurse manager
- spoke with five other staff members including doctors, nurses and occupational therapists

Summary of this inspection

- received feedback about the service from care co-ordinators and commissioners
- spoke with an independent mental health advocate
- attended and observed a multi-disciplinary meeting
- looked at care and treatment records of all patients
- carried out a specific check of the medication management

looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with eight patients who used the service. They all told us they felt safe at Millbrook. They said the staff were always kind to them and treated them in a dignified manner. They said they were included in all aspects of their care and that staff supported them with this. Patients told us staff were approachable all of the time and that they felt they had good relationships with them. Patients all said that the environment was always clean and tidy and that domestic staff did a brilliant job. Patients all reported the meals at Millbrook tasted good but some suggested they would like a bigger portion size.

We spoke with three carers of patients at Millbrook. They all said they were supported by the staff at Millbrook and that they felt welcome whenever they visited their loved one. Carers felt they were involved in their relatives' care where appropriate and their concerns were always listened to.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- the ward was clean, tidy and well maintained The clinic room was fully equipped and emergency equipment was checked regularly
- the ward used the short term assessment of risk and treatability (START) tool, which is a recognised risk assessment tool. This was regularly updated by staff and risks were managed appropriately
- staff were aware of how to report incidents and did so via the online incident reporting system
- the ward complied with guidance on same sex accommodation by having single ensuite bedrooms and a designated female lounge area
- there were good medicines management procedures for recording, dispensing and storing of medication
- staff were aware of the duty of candour and their responsibilities surrounding this.

Are services effective?

Good

We rated effective as good because:

- care plans were holistic, recovery focused and included the views of the patient. There was evidence that patients were offered a copy of their care plan and this was documented in their care record
- all patients had a physical health check on admission and there was evidence of ongoing physical health monitoring. There was good access to local physical healthcare services such as GP, dentist and opticians and patients were encouraged to use these
- care records were kept securely and were available to staff when they needed them, in an accessible form
- there was evidence that National Institute for Health and Care Excellence guidancewas being followed in relation to prescribing of medication and there was a range of psychological therapies on offer to patients
- clinical staff participated in a wide range of clinical audit, including medications, mental health act and care records
- all staff had received an appraisal in the last twelve months
- the mandatory training rate was 86%.

However;

Summary of this inspection

- not all staff had received quarterly supervision as per the managing performance policy.
- the section 17 leave file contained duplicate copies of section 17 leave authorisation and old leave forms which had not been struck through. This made it difficult to establish exactly what leave had been granted for some patients
- in some of the files examined there was no evidence of the approved mental health professional report completed at the point of detention.

Are services caring?

Good

We rated caring as good because:

- we saw positive interactions between staff and patient
- all patients we spoke with told us they were treated in a dignified, respectful and caring manner
- the staff we spoke with knew the patients well and this was reflected in the care plans of the patients
- patients all had a copy of their care plan if they wanted one and they were fully involved in developing them
- there were weekly community meetings where patients were given the opportunity to give feedback on the ward
- patients told us they were encouraged to join in with activities that were available in the local community.

However:

- there was no agreement in place with the advocacy service for the provision of a generic advocacy for informal patients.

Are services responsive?

Outstanding

We rated responsive as outstanding because:

- patients had access to a rehabilitation kitchen where they could cook their own meals and this was encouraged at least once a week. Patients living in the bedsits had a kitchen in their own room and did all their own cooking
- in the outdoor area there was a space where patients were growing their own vegetables, which could also be used in their cooking
- the service was a good example of social inclusion and there was a big emphasis on patients engaging in activities in the local community. This included a college course called “back on track”, which consisted of short six week courses on English and maths

- patients were encouraged to find voluntary work once they were well established in their recovery pathway. One example of this was one patient who gained a job despite there being over 100 applicants
- in the activity room there were two laptops that had access to the internet. Patients could use this to look for and apply for voluntary work
- leave beds were never used when a patient went on leave from the ward
- the service was discharge orientated, discharges were well planned and happened at an appopriate time for that person
- there was a full range of rooms to support care and treatment of the patients
- patients all had their own mobile phones and chargers and access to a telephone on the ward should they wish to make a phone call in private
- patients were able to personalise their bedrooms with photographs and other items from home
- patients were encouraged to maintain some form of physical exercise even if they could not engage with the gym program. On the wall of the ward there was a calculation of how many laps of the building patients would need to do to walk distances up to a mile. Patients engaged well with this and were keen to report to staff how many laps they were up to that week
- there had been no formal complaints about the ward in the 12 months before our inspection
- staff and patients were able to discuss any issues in community meetings and staff meetings
- information leaflets were available in a range of languages if required
- patients had access to an Independent Mental Health Advocate who visited the ward on a weekly basis.

Are services well-led?

Good

We rated well led as good because:

- staff were aware of the organisation's vision and values and these were displayed in the communal areas
- staff and patients had worked together to create a local logo which was displayed at the entrance
- the senior leadership were regularly at the hospital and staff knew their names
- all staff we spoke to told us they felt they made a difference to the lives of the patients they cared for.

However:

- sickness levels were at 9.5%

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- 85% of staff had up to date training in the Mental Health Act 1983 (MHA). Staff we spoke to showed a good understanding of the MHA relevant to their role
- we reviewed the medicine cards files for the detained patients and found that in all cases, treatment was given under the appropriate legal authority
- we reviewed the section 17 leave for the detained patients. We found that the patients were in receipt of daily leave in order to engage in community activities. We found that the parameters of leave were clearly documented
- administrative support and legal advice surrounding the MHA was provided by the local mental health trust
- we examined the detention and renewal documentation of four patients and found them to be in order
- patients had access to an independent mental health advocate (IMHA) who visited the ward on a weekly basis. Information about advocacy was displayed on the ward.

However:

- the section 17 leave file also contained duplicate copies of section 17 leave authorisation and old leave forms which had not been struck through. This made it difficult to establish exactly what leave had been granted for some patients
- in some of the files examined there was no evidence of the approved mental health professional report completed at the point of detention

Mental Capacity Act and Deprivation of Liberty Safeguards

- 85% of staff had up to date training in the MCA. Staff we spoke to showed a good understanding of the MCA relevant to their role
- there were no deprivation of liberty safeguarding applications in the 12 months leading up to inspection
- staff we spoke to showed a good understanding of MCA and explained how they had assessed patients capacity
- all patients were presumed to have capacity unless it was proven otherwise and independence was promoted on the ward

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

The ward provided a clean and spacious environment for patients. This included artwork by the patients and a ward logo at the door that the patients had created. There was access to two outdoor areas at all times, one of which was a vegetable garden that was maintained by the patients. There were smaller lounge areas where patients could go for some time alone or one to one time with staff (where patients meet individually with a named member of staff to discuss their care and treatment).

The ward had an up to date ligature risk assessment that the registered manager completed annually. This identified potential ligature points and plans were in place to mitigate these risks via patient risk assessments. Staff at Millbrook assessed patient risk of attempting to ligature prior to admission to consider if Millbrook was an appropriate placement for them. The ward was not ligature free but this was in keeping with positive risk taking in a rehabilitation ward. There were also four bedsit rooms, these consisted of a bed area and a small kitchen. Staff carried out risk assessments of patients prior to them moving into the bedsits from a single room.

The ward was mixed sex. It complied with guidance on same sex accommodation by having single ensuite bedrooms and a designated female lounge area. This ensures the privacy and dignity of all patients.

There were nurse call buttons in all bedrooms and bathrooms for patients to alert staff if they needed them. When these were activated, staff responded quickly.

There was a fully equipped clinic room with accessible resuscitation equipment including an automated external defibrillator. Staff checked this regularly and records were up to date. The clinic room was clean and tidy and contained a blood pressure machine and weighing scales. The clinical nurse manager did a weekly medication audit alongside the qualified nurse on duty.

There were no seclusion facilities on the ward and seclusion was not used. If a patient were to become unwell, they would be transferred to one of the acute mental health wards within the local mental health trust or a psychiatric intensive care facility.

The ward area was clean and had furnishings that were well maintained. The cleaning records were completed regularly by the domestic staff and were up to date when checked.

Handwashing facilities were available throughout the ward. This included sinks and gel hand wash stations. We saw that staff washed their hands at appropriate times, for example, after giving out medication and when preparing meals.

Safe staffing

The staffing levels at Millbrook were as follows:

Establishment levels: qualified nurses whole time equivalent (WTE) 6 there were no vacancies

Establishment levels: nursing assistants (WTE) 10 there were 2 vacancies

The number of shifts filled by bank and agency to cover sickness, absences or vacancies in the last 3 months was 47

Long stay/rehabilitation mental health wards for working age adults

Good

The number of shifts NOT filled by bank and agency to cover sickness, absences or vacancies in the last 3 months was 4

Staff sickness rate in 12 month period 9.5%

Staff turnover rate in 12 month period 17.6%

The agreed staffing establishment for each shift was one qualified nurse and three support workers in the day. The staff rotas confirmed this and this was supplemented during core hours by the clinical nurse manager and a senior nurse practitioner. At night there was one qualified nurse and one support worker. The day shift started at 07:30 and finished at 20:00 and the night shift started at 19:30 and finished at 08:00. The staff we spoke with felt the staffing levels were sufficient to meet the needs of the patients now the ward was almost fully staffed with just two vacancies for unqualified staff at the time of our inspection. Millbrook had an occupational therapist whose time was split between two Alternative Futures hospitals, spending half the week at each one.

In the three months leading up to our inspection there had been higher levels than usual of use of agency staff to cover vacancies and long term sickness. At the time of our inspection there was one member of staff on long term sickness and three vacancies for qualified staff had been filled. It was expected that due to this, the use of bank and agency staff would reduce over the coming months. The ward had employed an agency nurse on a short-term contract whilst waiting for the newly appointed qualified staff to start work. This meant that the staff were familiar with the ward. When the agency staff were not familiar with the ward they were given an induction on arrival to show them around and introduce them to the patients.

If there was increased activity on the ward or new staff, the senior staff had the authority to adjust staffing levels accordingly. For example, at the time of our inspection there were newly qualified preceptorship nurses on the ward and there was always another qualified nurse on the shift with them. This was confirmed by the staffing rotas. If additional staffing was required due to a patient needing higher levels of observation, for example, one to one nursing, this would need to be taken to the commissioners for extra funding.

All staff and patients we spoke with reported that activities and escorted leave were never cancelled due to short staffing. If for any reason leave had to be rearranged this was always explained to the patient and rearranged quickly. Staff reported this would only happen due to short notice sick leave and records reflected this. During our inspection we saw staff spending time and engaging with patients for most of the day. The patients had a one to one session with their key nurse at least once per week and care records confirmed this.

A consultant from the local mental health trust provided medical cover at Millbrook. The consultant attended the ward once a week for a ward round (each patient was reviewed at least once monthly). The staff reported they were always able to contact the consultant by telephone or email if there were any concerns around the patients, including medication changes required. Out of hours, the ward accessed the junior doctor cover at the local mental health trust for mental health related issues. They would use 999 in an emergency to ring an ambulance. All patients were registered with a local GP who provided medical support for physical health related issues.

All staff received mandatory training and the average mandatory training rate for staff was 86%. There were no significant concerns with any aspect of mandatory training overall with good uptake of all mandatory training. There was a system in place which alerted the manager when staff training was out of date and the ward administrative staff would book people onto the appropriate course.

Assessing and managing risk to patients and staff

Seclusion was not used at Millbrook and there were no seclusion facilities. Staff were trained in restraint techniques, however, there had never been an episode of restraint on the ward. Staff told us this was in part due to their in depth knowledge of the patients and collaborative care planning. Patients were able to identify their triggers for agitated or aggressive behaviour and with the staff put plans in place for what they felt would work to manage their behaviour in those situations. Patients explained to us that they used the community meeting as a chance to speak with other patients about any issues they may have before they built up to an argument so this reduced patient related incidents of aggression.

The ward used the short-term assessment of risk and treatability (START). This complies with the Department of Health Best Practice in Managing Risk guidance (2007) as it covers three of the five key areas to risk management that the guidance recommends should be assessed. The START

was completed on admission for all patients and records we reviewed reflected this. This was then reviewed at eight week intervals, when an incident occurred or when risks for that patient changed. We reviewed all ten patients care plans and all had an up to date risk assessment that had been reviewed on a regular basis.

During our inspection we did not see any restrictive practice on the ward and informal patients were able to leave at any time. Although the door was locked, there was a sign above the keypad with the code clearly marked so that patients could leave at any time. The staff reported that the locked door was to stop people entering the building and maintain patients' safety rather than to stop people leaving.

The ward had policies for observations. When patients were on the ward they were on general observations, which was checking six hourly.

Staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us. This was reported via the local council and staff told us how they would do this by ringing the safeguarding team to log the concern. There was a lead within the alternative Futures Group for safeguarding and all staff we spoke with knew who that person was and how to contact them. They also told us they could ring the local safeguarding team for advice around safeguarding if they needed it.

The ward had a medicines policy and there were good medications management practices. Medication on the ward was stored in a locked cupboard in a locked room. The pharmacist visited the ward weekly to check stock and complete audits, including high dose antipsychotic monitoring. Two patients were working through the stages of self-medicating and staff were facilitating this in line with the medicines policy. There was a staged approach to self-administering whereby patients were heavily supported in the first stage, getting less so as they moved through the stages. This included a risk assessment of how suitable the patients were to be able to take their own medication based on their understanding of why they needed to take the medication and how it worked. There was education available via one to one sessions with a qualified nurse during medication time for these patients around what the medications were, why they needed to take them and any possible side effects. When patients were self-medicating they kept their medicines in a locked cupboard in their bedroom and had their own key so they could access their medication when they needed to. For patients who were on Clozapine (an atypical antipsychotic that is used for treatment-resistant schizophrenia) there were monitoring processes in place that met with national guidance. This included regular monitoring of bloods and physical health checks.

There were several rooms that could be used for child visiting at Millbrook including the dining room, lounge and female lounge. However, all patients had unlimited unescorted leave and staff and patients told us that they encouraged meeting families in the community to normalise the visit.

Track record on safety

There had been no serious incidents reported in the twelve months leading up to our inspection. However, staff were able to explain to us how they would report serious incidents and how they were open and honest in relation to more minor incidents.

Reporting incidents and learning from when things go wrong

The ward used the online incident reporting system CARISTA. All staff had access to this system to report incidents. All staff we spoke to were aware of the system for reporting incidents and how to input data into the system. If staff were on shift that were agency then they would fill in a paper copy of the incident report and the ward admin would input this into the system the following day. When using this system to record an incident it would alert staff if the incident was reportable to any other bodies such as the local safeguarding authority and Care Quality Commission.

When incidents occurred, these were discussed in team meetings and any lessons learnt were identified. For example, there had been a medication error prior to the inspection which did not involve a patient. Staff received an email to say that this would be discussed at the next team meeting. Staff reported that this was talked about in an open and honest way and they were involved in identifying ways this could be managed differently in the future. For example, following this medication error, audits were done with the qualified staff on duty so that they could learn to identify errors and therefore try to reduce errors in the future. This was reflected in the meeting minutes.

Long stay/rehabilitation mental health wards for working age adults

Good

The ward also received alerts of serious incidents from other services within the Alternative Futures Group via a "risk alert". These were also posted on the "buddy" system, which is an internal intranet for staff. All registered managers attended monthly quality assurance meetings where lessons learnt from other hospitals within the organisation were discussed and then managers could feedback to their individual teams.

Staff were aware of the duty of candour and the need to be open and transparent when an incident occurred.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed all ten patients care records during our inspection. Care plans were developed in collaboration with the patients. The care plans were both holistic and recovery focused. Patients had all been offered a copy and this was signed for at the bottom of the care plan. We saw patients' care plans in a file in their bedrooms. Patients who had refused a copy had signed to say that they had been offered a copy but had refused. Care plans were in the form of the wellness recovery action plan (WRAP) which allowed the patients to set their own goals with support from staff. This also identified triggers and a crisis plan for when things did not go to plan. The WRAP was supported by the use of the recovery star, which is a tool to create recovery-focused care plans in order to optimise individual recovery. The recovery star allows patients to plot their improvements to see how well they are progressing in order for staff to measure outcomes.

Every patient had a physical health check on admission. There was evidence in all records of ongoing physical health monitoring. This included blood tests being carried out and weights and blood pressures being documented weekly. There was a weight loss reduction programme led by the staff. This was particularly focused around education about what types of foods are healthy and portion sizes. There was an element of exercise incorporated into this. For example there were signs around the building to say how many laps equalled a mile walk and initiatives such as walking to the next bus stop along each time they caught the bus. Two patients were taking part in a weight reduction programme with the support of the staff. This included them making a shopping list of healthy meals and going shopping for the ingredients to cook the meal. This had proven to be successful with one patient losing around 5kg in weight.

Care records were stored securely and kept in paper format. All staff had access to the records when they needed them.

Best practice in treatment and care

We reviewed all the medication charts at Millbrook and we saw evidence to show that staff were following National Institute for Health and Care Excellence (NICE) guidance. The pharmacist carried out a monthly review of patients that were on high doses of antipsychotic medication. Where suitable these were reviewed and reduced.

Best practice guidance around rehabilitation services in mental health is provided by the Royal College of Psychiatrists. The emphasis of this guidance is about social inclusion and the patient being supported and involved in their recovery so that they can eventually live independently in the wider community.

During our inspection we found that there was a range of recovery focused activities at Millbrook. There was also a range of psychological activities available for the patients. NICE guidance recommends cognitive behavioural therapy for people with a long term diagnosis of a psychotic illness. There were staff trained to deliver this and were using it with patients on the ward. There were other psychological therapies available such as family intervention therapy and work around coping strategies. Patients had access to a team of therapists including psychologists who were based at the Alternative futures Group head office. Staff told us that they would refer patients to the team on an individually assessed basis. There were a number of other activities available for patients such as art groups, reading groups and walking groups. There was a vegetable garden that patients tended to in the summer months.

There was good access to physical healthcare at Millbrook. There were good links with the local GP where all patients' were registered when they were admitted to the hospital. Patients' had access to health promotion schemes such as smoking cessation. There was access to a specialist of

patients' required such as cardiologist or diabetic services, this was provided at the local hospital via the GP. Staff assessed patients' nutrition and hydration using the Malnutrition Universal Screening Tool (MUST). Staff told us that a dietician at the local GP surgery would provide support when risks were indicated on the MUST.

Staff used the Health of the Nation Outcome Scale to assess and record symptom severity and monitor patient outcomes. The recovery star was also used to measure outcomes for patients'. The recovery star allows patients to plot their improvements to see how well they are progressing, this was done collaboratively with the patient and the staff.

The staff on the ward were involved in clinical audit and were able to show us the outcomes of these. These included medication audits, records audits and mental health act audits. Staff were able to show us how changes had been made following the outcomes of audits. For example, medication audits were carried out with qualified staff on duty so they were involved in the process and understood why this was being done. This meant they were aware of common errors and could be extra vigilant in those areas.

Skilled staff to deliver care

The ward was staffed by a multidisciplinary team. This included, nurses, occupational therapist, a consultant psychiatrist, administrative staff, support workers and a clinical manager and a registered manager. The pharmacist visited the ward weekly and was available on the telephone during working hours. There were also domestic staff and catering staff who were employed by a private company but they worked solely at Millbrook.

The policy for managing performance stated that staff should have supervision every quarter. We found that most staff had received quarterly supervision, however, three had not. Staff reported that this had been due to short staffing on the ward prior to Christmas and the manager was aware of this. There was a plan in place for all staff to receive supervision now the staffing establishment was increased. Staff who were delivering supervision told us they had had training in how to do this. 100% of non-medical staff members at Millbrook had received an appraisal in the last 12 months. Newly qualified staff were being supported through preceptorship during our inspection. These staff had received more regular weekly supervision from the clinical manager plus training with the pharmacist around medications.

Staff told us they were encouraged to undertake additional training to that which was mandatory. We saw evidence of this in staff files. This included two new nurses undertaking cognitive behaviour therapy training and support staff undertaking NVQs. Staff told us they received monthly emails about other training opportunities within the Alternative Futures group that they could access. All new staff were undertaking the care certificate as part of their induction. For staff that had been there for some time this was done as part of their ongoing training to refresh their knowledge.

There was a clear structure in place to manage performance levels and managers were able to describe how they would implement this to address areas of poor performance within the team.

Multi-disciplinary and inter-agency team work

There were regular multidisciplinary team meetings (MDT) held at Millbrook. These occurred weekly with each patient having a slot once per month. However, if patients needed to see the doctor they could do so even if it was not their week to be seen by requesting a slot at the end of the MDT. This included the consultant psychiatrist who was based within the local community mental health team, staff at Millbrook, families of patients and care coordinators from the patients' community mental health teams. The ward had good links with the local GP and they managed the physical health of the patients. All patients' were registered at the local GP on admission.

The Care Programme Approach (CPA) provides a framework for the effective delivery of care for people with severe mental health problems. Meetings to support this process should be arranged on a regular basis depending on the needs of the patient. Staff reported that they struggled to arrange CPA meetings as community based care coordinators were too busy to attend. They felt this had an impact upon discharge planning for the patients at Millbrook. Staff had requested a meeting with the local community mental health team to discuss this and try to improve the working relationship between the teams.

Long stay/rehabilitation mental health wards for working age adults

Good

Handovers occurred at every change of shift and other professionals such as occupational therapists as well as nursing staff were encouraged to attend.

Adherence to the MHA and the MHA Code of Practice

The ward provided us with data about Mental Health Act (MHA) training. At the time of our inspection 85% of staff had up to date training in the MHA. Staff we spoke to showed a good understanding of the MHA relevant to their role.

During our inspection, a Mental Health Act reviewer looked specifically at the care records of people who were detained under the MHA. We reviewed the medicine cards file for the detained patients and found that in all cases, treatment was given under the appropriate legal authority. The medicine cards file was in good order; for each patient there was either a capacity assessment form or a record of discussion of consent for patients who had capacity to make the decision themselves. We found that some patients were self-medicating. For these patients a copy of the self-medication care plan, medication safety assessment and self-administration consent form was included in the medicine card file.

We reviewed the section 17 leave for the detained patients. We found that the patients were in receipt of daily leave in order to engage in community activities. We found that the parameters of leave were clearly documented. Risk assessments were completed before the leave was authorised and were found on the reverse of the section 17 form.

The leave file contained a section 17 leave form which was in date but had been crossed out, which made it appear as though it was no longer current. The patient it referred to was out on leave during the day. The staff were able to locate a copy of the form that had not been crossed out in the patient's legal file and told us that a 'rescinded leave' form would be in place for any leave that had been cancelled.

The leave file also contained duplicate copies of section 17 leave authorisation and old leave forms which had not been struck through. This made it difficult to establish exactly what leave had been granted for some patients.

Administrative support and legal advice surrounding the MHA was provided by the local mental health trust.

We examined the detention and renewal documentation of four patients and found them to be in order. In some of the files examined there was no evidence of the approved mental health professional (AMHP) report completed at the point of detention.

There were regular audits of the MHA undertaken by the clinical lead on the ward. This was done with support from the MHA admin team at the local mental health trust who took responsibility for MHA paperwork for the hospital.

Patients had access to an independent mental health advocate (IMHA) who visited the ward on a weekly basis. Information about advocacy was displayed on the ward. The IMHA confirmed that detained patients were supported and encouraged to involve the advocate.

Good practice in applying the Mental Capacity Act

The ward provided us with data about Mental Capacity Act (MCA) training. At the time of our inspection 85% percent of staff had up to date training in the MCA. Staff we spoke to showed a good understanding of the MCA relevant to their role.

There were no deprivation of liberty safeguarding applications in the 12 months leading up to inspection.

Staff we spoke to showed a good understanding of MCA and how they had appropriately assessed patients capacity. All patients were presumed to have capacity unless it was proven otherwise and independence was promoted on the ward. One example of this was around the management of money for one patient. This was assessed using a capacity assessment and a best interest decision and an appointee was identified following these discussions. This was documented in the patients care record and also in their care plan.

There was a policy for MCA that the staff were able to access should they need to use it. During the inspection staff were able to show us where this was located

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

Long stay/rehabilitation mental health wards for working age adults

Good

During our inspection we observed interactions between staff and patients. We observed all of these to be kind, respectful and responsive to patients' needs. Staff used patients' preferred names and all patients told us they felt comfortable with the staff. All patients praised the staff for being approachable and supporting them at all times.

All the staff we spoke with knew the patients well. They were aware of their care plans and understood the needs of each patient. They worked together with the patients to set goals that were recovery focused.

Carers we spoke to told us that their relatives were treated with kindness and that they would recommend Millbrook as a place for others to recover well.

We spoke to eight patients during our inspection. All patients told us that they felt safe and that they had never witnessed any restraint. Some comments we received were, "staff here are very kind", "I feel relaxed here", "the staff are all polite", "I am never forgotten".

The involvement of people in the care they receive

There was an in-depth admission process that ensured patients were orientated to the ward prior to their admission. Patients visited the ward and met the staff that would be caring for them. This included families and carers should the patient consent to their involvement. On admission, the key worker started to complete the care plan for that patient, including baseline checks and an initial care plan with basic information about the patient. Each patient's record contained an "all about me" document that contained details of things they enjoyed, hobbies and things that were important to them. This was a good tool for any new staff coming to the ward as they had a quick reference guide to get to know a little about each patient. It was clear that patients had been involved in completing these and that time was spent enabling them to do this.

We reviewed 10 patient care records and all care plans had been completed with the patient. This included patients writing their care plan out themselves using language that they understood and recognised. The patients set their own goals and staff supported them to plan how they would work towards achieving these goals.

During our inspection we observed a multidisciplinary team meeting. This included the patient and their family (if the patient wanted them to be involved). Every aspect of the patient's care was discussed with the patient. There was time for the patient to express their views and it was clear that these views were listened to. No decisions were made prior to speaking with the patient. Time was given for family and carers to speak about how they felt their relative was recovering and all staff involved listened to them.

We observed a patient meeting during our inspection. This was in the main lounge and all patients were encouraged to attend. This was to give their feedback on the ward and have input into future decisions. For example, some of the topics discussed included days out, menus and themed event days.

Detained patients we spoke with were aware of the advocacy service provided by Manchester Advocacy. They knew when the advocates visited and why they came. There was information on the patient information board about their role and how to contact them. However there was no agreement in place for the provision of a generic advocacy service for informal patients.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Outstanding ☆

Access and discharge

In the 12 months leading up to our inspection there were eight discharges from Millbrook Hospital. Average bed occupancy over the last six months was 83% and at the time of our inspection there was no waiting list.

Staff from Millbrook attended the citywide rehab referral meetings on a monthly basis. This meeting was attended by all other rehabilitation facilities in the local area to discuss referrals and to decide on the most suitable place for that patient. Staff explained that this meant they learnt the specialities of other rehabilitation facilities and they could learn about theirs. This meant that patients were placed in the most suitable place for them to recover well and failed admissions could be avoided.

There was on ongoing process of bringing patients back to the local area who had previously been placed far away

from home due to lack of suitable placements. Millbrook supported this and worked with the local clinical commissioning group to move patients who were as far away as Cornwall back to their local area.

At the time of our inspection there were four delayed discharges. This was due to the lack of suitable places for the patients to move on to in that area. During the multidisciplinary meeting, we saw evidence that Millbrook was looking at other options for these particular patients, to speed up the discharge process. For example, they were looking at private tenancy agreements with a team of support staff visiting the patient in their own flat. This had to be carefully risk assessed with the risks of those particular patients kept in mind. Another example was looking at suitable placements that had smaller waiting lists in areas near to the patients' preferred place, with a view to moving to the preferred place when it became available.

Patients going out on leave always had a bed on return. Commissioning arrangements meant that leave beds could not be used. Most admissions came from the acute wards at the local mental health trust but some admissions were taken from forensic services. Should a patient relapse and require more intensive treatment whilst in the ward they would usually be admitted to one of the acute wards at the local mental health trust. There was a psychiatric intensive care unit available within that trust.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment on the ward to support treatment and care. There was a clinic room that could be used to examine patients although each patient had their own room so this could also be used. There were two small lounges where patients could go to spend time alone or to meet with staff. There was also a good size activity room with access to games equipment and the outdoor area, which could also be accessed via the main corridor on the ward. All patients had their own mobile phones and could use these in the privacy of their own room if they wanted to make a private phone call. However, if patients did not have access to their own mobile phone there was also a phone room on the corridor that could be used to make a private call.

There was a chef employed at Millbrook who cooked all the food on site. The menus were on a four weekly rota system. All patients reported the food was nice but four requested larger portions. However, the menus were calorie controlled and were developed alongside a dietician. Patients had access to snacks and hot drinks twenty-four hours a day. For example, if a patient missed a mealtime due to being on leave, then a sandwich was provided on their return. Patients also had access to a rehabilitation kitchen where they could cook their own meals and this was encouraged at least once a week. Patients living in the bedsits had a kitchen in their own room and did all their own cooking. Staff supported them in this, for example, budget planning for food and making lists of ingredients they needed to go shopping for. Patients had access to a store cupboard that contained basics such as rice, pasta and potatoes in order to support their meal planning. In the outdoor area there was a space where patients were growing their own vegetables, which could also be used in their cooking.

In all patient bedrooms there was a lockable space where patients could store their valuables if they wished. They had a key to access this at all times. We saw evidence of patients personalising bedrooms with photographs of family and friends. They also had items from home and posters and artwork completed in group work. In the activity room there were two laptops that had access to the internet. Patients could use this to look for and apply for voluntary work.

There was a big emphasis on patients engaging in activities in the local community. This included a college course called "back on track", which consisted of short six week courses on English and maths. There were good links with the local gym where patients attended to exercise and help with weight loss programmes. There was also reduction and motivational programme (RAMP), a 12 week motivational programme for adults to encourage abstinence or reduce use of drugs and alcohol. Patients were encouraged to find voluntary work once they were well established in their recovery pathway. One example of this was one patient who gained a job despite there being over 100 applicants. There were also lots of activities available on the ward each day, including evenings and weekends. This included art, reading, gardening, cooking, relaxation, fitness groups and pamper sessions. Patients were encouraged to maintain some form of physical exercise even if they could not engage with the gym program. On the wall of the ward there was a calculation of

Long stay/rehabilitation mental health wards for working age adults

Good

how many laps of the building patients would need to do to walk distances up to a mile. Patients engaged well with this and were keen to report to staff how many laps they were up to that week.

Meeting the needs of all people who use the service

The ward was fully accessible for physically disabled people. The showers were all wet rooms style so accessible for people in a wheelchair or with impaired mobility. There was also a large assisted bathroom that patients could use with support of staff if required.

Patient information leaflets were available about a range of treatments, mental health illnesses and medications. These were obtainable in different languages and formats if they were required. There was access to an interpreter service and this was accessed via an online booking system that all staff had access to. Patients were encouraged to maintain links with their local spiritual support networks by attending local churches, mosques or other religious meeting places. Staff provided support if the patients felt they needed it. As all of the food was cooked on site the chef was able to tailor the menus to suit specific dietary requirements. The chef would attend the patient meetings to discuss requirements with patients'. For example if someone was vegetarian, coeliac or required a specific diet for religious purposes. The chef was able to shop with the patients for the correct items or order via the usual food ordering system if patients were not able to go shopping.

During our inspection we saw information explaining to patients how to complain if they wanted to. There was information about their rights under the Mental Health Act 1983, and the internal complaints process for the Alternative Futures group. Patients we spoke with knew how to complain and felt that they would feel confident to do so if they had an issue to raise.

Listening to and learning from concerns and complaints

There had been no complaints about Millbrook in the twelve months leading up to our inspection. There was information on the wall about how to complain and who to contact to do this. Patients we spoke with told us they were given information on admission about how to complain and we saw evidence of this in the admission information pack. However, all patients we spoke with said that they found the staff approachable. They told us that should they have a problem they would feel at ease talking to the staff about this and were confident their issue would be listened to and resolved.

During the inspection we saw lots of thank you cards on the walls and in the office. These were not only from patients but from family and student nurses. They were all complimenting the service on the care, treatment and support they had individually received.

Staff we spoke with were aware of the complaints procedure and were able to explain this to us. Staff told us they encouraged an open culture at Millbrook and that their relationships with the patients meant they could discuss issues in an open and honest way. If a patient raised a concern, then if it was appropriate, this would be discussed in the patient meeting each week. We saw evidence of this in the minutes from the meetings, for example people's concerns around portion size of meals. There was evidence this was discussed and reasons behind portion control was explained as being important for health and weight management.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

The vision at Millbrook was "a world where people control their own lives". This was displayed clearly around the ward and staff were able to tell us what this was. In a recent staff survey provided to us by the ward 77% of staff reported they knew what the vision was for the service both nationally and locally. The vision for the service links in with the values, which were to be principled, reflective, dynamic and empowering both within themselves and towards patients. Staff maintained these values through the work they did with the patients; this was evident in the person centered care plans and the interactions we observed between patients and staff. Patients and staff at Millbrook had developed their own logo during art groups.

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Good

This consisted of a dove, a rainbow and words such as "hope" on it. Staff and patients had worked on this together and had all given ideas on what to include. Patients had suggested this logo was put onto t-shirts for staff to wear.

Staff were able to tell us the names of the more senior people in the organisation. Some of these people were present during the inspection but staff told us that they did visit regularly anyway. Staff told us that they felt confident to go to their immediate manager if they had a problem and that they felt they would be listened to. However, some staff felt that due to short staffing and recent changes in the management structure, this had not always been the case over the last few months but this had started to improve.

Good governance

Staff at Millbrook had attended mandatory training and managers supported them to do so by allowing time to go to training. All staff at Millbrook had received an appraisal in the last twelve months and supervision on a quarterly basis. During our inspection we found that this had been adhered to for the most part but that three staff files showed that supervision had been less than quarterly.

There were sufficient staff on each shift to ensure that patient care was maintained. If patients needed higher levels of observation then the commissioner would fund this and extra staff would be brought in to support these patients.

Staff were involved in clinical audit and were aware of why this was done. There was evidence of changes made following clinical audit. For example, staff had audited care plans and found they were not always goal-orientated but more problem-led. There was a training day for staff around what a care plan should contain and how to use more positive language.

All staff were able to tell us how incidents were reported via the online incident reporting system. All staff had access to this but there was also a paper copy if people struggled with the computer and senior staff could assist them in inputting this.

We reviewed 10 care records during our inspection. These all showed that staff regularly spent time interacting with patients. This was in many forms such as formal one to one sessions, meetings around care planning and just for an informal chat.

The managers attended a quality assurance framework meeting monthly. During this meeting they could discuss incidents from other Alternative Futures Group sites and take learning from these incidents back to their own teams.

Key performance indicators (KPIS) were used to gauge performance of the team. This was available to managers in a dashboard format. This was broken down into locations so managers were able to measure the performance of their team against other similar teams. KPIS for Millbrook included medication errors, length of stay and relapse rates. These were discussed quarterly with each region at a performance senate with the quality lead and the clinical director. Prior to this meeting, managers were asked to look at any areas for development in their teams and then they developed action plans in conjunction with the quality lead for the ward. This was then fed back to the team at staff meetings and issues from the team were fed back up to the senior management team via these meetings.

Leadership, morale and staff engagement

Sickness levels at the time of our inspection were 9.5%. This was above the national average of 5%. The managers were aware of this and were working within the organisation's sickness policy to manage it and supporting individual staff to improve this. There were a small number of staff on long term sickness leave and this attributed to the higher percentage of sickness. Staff we spoke to who had recent episodes of sickness reported they were very well supported by the manager during this time. This included visiting staff at home, arranging referral to counselling services and ensuring that staff did not feel pressured to come back to work before they were ready, this was supported by a phased return.

We did not find any evidence of bullying or harassment. Staff we spoke with had someone they could go to for support if they had a problem. They felt they were listened to and that they would not fear victimisation if they spoke up. All staff were aware of the organisation's whistleblowing policy. All staff we spoke to said that they felt they made a difference to the lives of the patients they cared for. They felt that the service was truly recovery focused and person centred. This was clear in the care plans but also in the genuine relationships we observed between staff and patients.

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Good

At the time of our inspection the organisation had recently committed to a new form of training for managing violence and aggression. This was moving from a more planned intervention approach to one that could be used in an unplanned situation of violence. Some staff who were unable to complete the training were being offered redeployment. Some staff we spoke with reported that this had brought morale in the team down as they felt the team worked well together. This was being managed sensitively and staff that were involved were being kept up to date with any developments surrounding this issue.

Commitment to quality improvement and innovation

The hospital had a programme of audits that informed improvements in service delivery and practice. Managers reported the outcomes of audits and associated action plans to the quality improvement lead.

The hospital was not participating in any national quality improvement programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- the provider should ensure that all staff have received quarterly supervision as per the managing performance policy
- the provider should ensure there is an agreement in place with the advocacy service for the provision of a generic advocacy for informal patients
- the provider should ensure that there is an appropriate system in place for filing old copies of section 17 leave forms to ensure it is clear exactly what leave has been granted for patients
- the provider should ensure that there is a copy of the approved mental health professional report completed at the point of detention in patients records

the provider should continue to ensure that they aim to reduce sickness levels from 9.5%