Requires improvement

Priory Healthcare Limited

The Priory Hospital Southampton

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-127132309	The Priory Hospital Southampton	The Priory Hospital Southampton	SO40 4WU

This report describes our judgement of the quality of care provided within this core service by The Priory Hospital Southampton. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by The Priory Hospital Southampton and these are brought together to inform our overall judgement of The Priory Hospital Southampton.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

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Overall summary

We rated the Priory Hospital Southampton as requires improvement overall.

Through the inspection process, we identified a number of serious concerns in relation to the governance and operation of the service. This has resulted in our taking separate enforcement action in order to ensure the provider takes immediate actions to address the concerns identified. We have since returned to check that the provider has made improvements required and we found that they have improved a number of their governance and management systems to improve safety.

When we undertook the inspection we found that the provider had not taken appropriate steps to ensure the safety of patients and staff at the service. We found there were gaps, errors and weaknesses in the service's assessment and management of risk. We found that the provider had not taken effective steps to address the risk of ligatures on each of the wards. We identified a number of concerns in relation to the use, level and monitoring of restraint and rapid tranquilisation of patients at the service, specifically vulnerable younger people on the child and adolescent mental health services (CAMHS) ward. There was a lack of senior oversight of the safeguarding log. This meant the provider did not ensure that staff in all instances had followed safeguarding processes fully and that appropriate actions had been taken in a timely manner.

We identified serious concerns in relation to the provider's systems for reporting incidents and learning from when things go wrong. Poor and inaccurate recording and reporting of incidents, lack of senior oversight and inconsistent investigation meant that the provider could not assure itself that incident data was accurate and reflected the actual number or detail of incidents, or the current risks within the service. It also meant that the provider might not have identified potential trends or near misses. The provider, in relation to the detail, quality and completion of incident reports, had highlighted a number of concerns in its own quality reports. However, the reports had not identified potential issues in relation to the management of incidents, or that there were a sizeable number of moderate and serious incidents requiring further investigation. The service's risk register did not have clear action plans in place to mitigate the risks identified. Additionally, we did not see evidence to demonstrate the risk register was regularly reviewed and updated by either the provider or the service's management team. It was not clear how the senior team, or the Board, assured themselves that these risks were being addressed effectively and with the appropriate urgency and focus.

We identified a number of concerns in relation to the use and monitoring of restraint and rapid tranquilisation of patients at the service, specifically vulnerable younger people on the CAMHS ward. We therefore recommend in this report that the provider should carry out a detailed review of the use, level and monitoring of restraint and rapid tranquilisation at the hospital, with particular attention to their use in the treatment of young people on Kingfisher ward.

We found there was variance in quality and identified gaps and inconsistencies in some care plans. We had concerns in relation to the existence and use of parallel electronic and paper based records, which meant there was a risk staff may refer to out of date records.

At the time of inspection, the hospital director was the fourth person to hold that post since December 2014 and had been in post for six weeks. A new CAMHS consultant was due to take up post in December 2015. The site's risk register had identified the lack of substantive hospital director and CAMHS consultant as increased risks. We found there was reduced senior and clinical oversight at the service, and that the provider was aware of increased risks for serious incidents associated with CAMHS wards. Staff had been given insufficient opportunity to give feedback on services and the systems and processes for staff engagement did not seem sufficiently robust. There was no evidence of formalised staff consultations taking place in the last two years, and some staff were unsure about the company's values and vision and told us they felt a little isolated from the wider organisation.

However, there were also some positive findings:

At a local level, ward managers were highly thought of by their staff teams and were able to lead with appropriate authority. Staff described morale as good on each of the wards, and told us that colleagues and managers listened to and supported them. The newly appointed hospital

Summary of findings

director was extremely positive during discussion and talked enthusiastically about improving processes and systems at the hospital for the benefit of patients. They acknowledged and responded openly and constructively to feedback from inspectors during and after our inspection visit. Following our visit we saw immediate evidence of the hospital director making improvements at the service, and were encouraged that they would take a key role in making necessary changes to drive wider long term improvement in the quality of service provision.

There was an appropriate standard of hygiene and cleanliness at each of the three wards. Staffing figures were generally at the established figures for each of the wards, which both staff and patients told us was usually sufficient.

Comprehensive examinations of people's physical status and assessments of their mental health needs had been carried out by staff at or soon after admission to the hospital. Patients on the three wards were offered a variety of different psychological therapies. A wide range of staff including medical, psychology, occupational therapy and pharmacist supported wards. Medical, therapy and senior nursing staff were experienced practitioners.

We observed that staff treated people with compassion and were sincere and caring in the way they interacted and gave support. The patients we spoke to in person were generally positive about staff who they said treated them with kindness, dignity and respect. Patients were involved in the planning of their own care. On each of the wards, patients confirmed they either had support from an independent advocate or knew the support was available to them if ever they wanted it. We saw evidence that patients, carers and family members were involved appropriately in decisions about care and treatment.

The average bed occupancy across the three wards meant the service was generally able to admit patients quickly, and wards could keep their beds available for them to return to when they went on leave. Each of the wards had a range of different rooms and equipment to support treatment and care. The food provided was of good quality, and the service was able to provide a choice of food in order to meet the dietary requirements of different religious and ethnic groups. Staff were aware of patients' individual needs and tried to ensure they met them. This included cultural, language and religious needs. The majority of staff were up to date with their mandatory training and received regular supervision.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We identified multiple ligature points at each of the three wards. We found evidence that there had been a significant number of incidents involving ligatures in the previous 12 months. In light of the high level of risk of harm to patients on Kingfisher ward from ligatures and the high number of ligature incidents, we did not receive necessary assurance that the provider had taken effective steps to address the risk of ligatures on the ward.
- The layout of wards did not allow staff to observe easily all parts of the wards. This presented different degrees of risk to patient safety, according to the ward and patient group.
- Although risk assessments had been carried out for every patient on or soon after admission and were present in each of the records inspected, they varied in quality and effectiveness and we identified a number of gaps, errors and weaknesses in the service's assessment and management of risk.
- We identified a number of concerns in relation to the use and monitoring of restraint and rapid tranquilisation of patients at the service, specifically vulnerable younger people on the CAMHS ward.
- We identified serious concerns in relation to the provider's systems for reporting incidents and learning from when things go wrong. The failings identified meant it was subsequently extremely difficult for the inspectors, local commissioners and the provider itself to get a clear understanding and accurate assessment of the service's safety track record. We have taken separate enforcement action against the provider regarding these parts of the 'safe' domain.
- There was not an open culture of incident reporting at the service. For example, we noted that staff had been directed by managers to record multiple incidents on single incident forms for patients, or not to record `minor` incidents on incident forms.From discussion with senior staff, we found there was a lack of clarity around the use of incident reports. This had the potential to affect how risks were identified and subsequently recorded across the service.
- We found evidence that a significant number of incident forms weren`t completed accurately. Incident forms and summary spreadsheets lacked the detail required to enable a clear picture of what actually happened.

Summary of findings

- We were concerned that while there were systematic measures in place to report and record safeguarding allegations, these were implemented inconsistently by staff, which was out of line line with the Priory Group safeguarding policies, which reduced internal and external oversight. Whilst safeguarding incidents and concerns were recorded in a safeguarding log, we found there was not any senior oversight of the safeguarding log to ensure that the safeguarding processes had been followed fully by staff in all instances and that actions had been taken in a timely manner by them.
- Night shift staff on Skylark ward were supplied and managed through Sandpiper ward. Staff and patients told us this affected the consistency of staffing. Skylark ward was due to take control of its own staffing, which would likely address the problem of consistency, but a final date for this had not been set at the time of our visit.

However:

- The wards were designed to comply with relevant national guidance on same-sex accommodation.
- All equipment in clinic rooms was clean and well maintained. Emergency medicines were all in date and stored appropriately.
- There was an appropriate standard of hygiene and cleanliness at each of the three wards. The wards had good quality furnishings, were well maintained and in a good state of repair.
- Staff carried out a range of environmental, health and safety checks, and risk assessments on each of the wards. Alarm or call systems were available in each room for patients and the majority of front line staff carried personal alarms.
- The provider used its own staffing 'ladder' tool to identify how many staff should be on duty in relation to the number of patients. Staffing figures were usually at the established figures for each of the wards.
- Ward managers told us that staffing was generally sufficient, and they were able to alter staffing levels in order to meet the needs of the patient group. We observed sufficient staff were present in communal areas of wards when patients were present. Patients confirmed they were able to have regular one to one time with allocated staff, which they found to be helpful.
- There was adequate medical cover available day and night, and a doctor was able to attend the wards quickly in an emergency.
- Most staff were fully up to date with their mandatory training.

Summary of findings

- Staff we spoke with showed a good understanding of safeguarding procedures. Safeguarding training was provided for all employees, and the level of training adapted according to an employee's role within the service.
- Processes and systems were adequate to ensure the safe management of medicines.
- Staff told us they met together for discussion after serious incidents and that debriefing sessions were organised for them after such events.

Are services effective?

Good

We rated effective as good because:

- Comprehensive examinations of people's physical status and assessments of their mental health needs had been carried out by staff at or soon after admission to the hospital.
- Care plans and confidential records were stored securely and available for staff use as appropriate.
- Wards generally worked within National Institute for Health and Care Excellence (NICE) guidelines in respect of the prescribing and management of medication. The pharmacist visited wards weekly and carried out checks to ensure prescribing was within guidelines.
- Patients on the three wards were offered a variety of different psychological therapies. Therapies included cognitive behavioural therapy (CBT), family therapy and eye movement desensitisation and reprocessing (EMDR) therapy. Occupational therapists did sensory therapy and worked with patients to look at relaxation techniques and at alternatives to self harm.
- Care records contained evidence that patients had access to physical healthcare, including the intervention of specialists, when needed.
- Staff took part in a range of clinical audits.
- A wide range of staff including medical, psychology, occupational therapy and pharmacist supported wards. Medical, therapy and senior nursing staff were experienced practitioners. Staff at each of the wards told us they received regular supervision and felt well supported.
- Staff were able to request and receive additional specialist training if they identified specific gaps in their knowledge.
- Staff on each ward told us that their multi disciplinary teams worked well together, and this was in line with our own

observations. Staff told us they felt working relationships with external organisations were also generally good. We saw evidence of effective liaison and communication with external agencies in people's care records.

However:

- We looked at 17 patients' care records in total across the three wards. We found there was some variance in quality and identified gaps and inconsistencies in some care plans. The care plans on Sandpiper ward in particular were not sufficiently patient centred.
- We identified concerns in relation to the existence and use of parallel electronic and paper based records. We saw instances where the written notes contained more detailed and up to date information concerning the patient's condition and progress, but they had sometimes not been uploaded electronically by staff in a timely manner. This meant there was a risk staff may refer to out of date electronic care records.
- There was scope for greater emphasis on effective medicines optimisation. For example, there were no formal patient involvement sessions with the pharmacist and we saw no evidence that patients were encouraged to seek information or to discuss medicines with them.

Are services caring?

Good

We rated caring as good because:

- We observed that staff treated people with compassion and were sincere and caring in the way they interacted and gave support. Staff engaged with patients in a respectful manner, and were discreet and respectful when discussing personal issues with them. The patients we spoke to in person were generally positive about staff who they said treated them with kindness, dignity and respect.
- Admission processes informed and oriented patients to the ward and service. Information packs were given to all new patients to inform them about their stay and the level of service they should expect.
- We saw ways in which patients were involved in the planning of their own care. For example, we saw patients actively participated in their own CPA meetings. Patients told us they had received or been offered copies of their own care plans, and confirmed they were involved in their own care when they wanted to be.

Summary of findings

- Information about how patients could access independent advocacy support was displayed clearly on notice boards and patients spoken with on each of the wards confirmed either an advocate supported them or they knew the support was available to them if ever they wanted it.
- Families and carers of patients were encouraged to be involved in the ongoing process of care planning and delivery. We saw evidence that patients, carers and family members were involved appropriately in decisions about care and treatment.
- We saw a number of positive ways in which patients were able to give feedback on the service they received. For example, regular ward community meetings gave patients opportunities to speak up about any concerns they had and to give their feedback as to how things were done on the wards.
- Patients were able to get involved in decisions about their own care and the wider service provision, which included involvement in the recruitment of staff. The provider had approached a recognised mental health charity to enable the input of the patient voice to the interview panel.

However:

- Feedback from patients was not unanimous, and during the inspection, we received some negative comments. We also collected anonymised feedback from patients using comment cards. The feedback received on the cards was mixed, but the majority of comments received via these forms were collected from Kingfisher ward and were negative.
- We found there was inconsistency between the three wards as to how effectively some patients were involved in the planning of their own care and treatment. For example, we attended a CPA meeting for one patient and noted that all key decisions concerning the patient were made before the patient was invited into the meeting. Staff did consult with the patient, but the key decisions had already been made.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The average bed occupancy across the three wards generally meant the service had been able to admit patients quickly. Further, it meant that wards could keep patients' beds available for them to return to when they went on leave.
- The environment on each ward was clean and comfortable, and the furnishings and decoration were in good condition

throughout. Each of the wards had a range of different rooms and equipment to support treatment and care. Informal patients had free access to the extensive and attractive grounds surrounding the hospital.

- The feedback received from patients on each ward was that the food provided was of good quality. On each ward, there was also a small kitchen for patients to use to make snacks and warm drinks. The service was able to provide a choice of food in order to meet the dietary requirements of different religious and ethnic groups.
- Patients had access to a range of activities. There was good access to ward based activities as well as a range of activities outside of the hospital.
- Patients told us that if they had cause to complain, they were confident the ward managers and other senior staff would take their complaints seriously. Information on how to make a complaint was displayed on the wards and in the welcome packs for patients. Informal complaints were reported by staff and patients as being dealt with at ward level and in weekly community meetings.

However:

- We identified a specific problem in relation to the environment on Kingfisher ward. A loud alarm went off repeatedly, warning staff on the ward of incidents in other parts of the hospital. We found this was disruptive, and not conducive to creating a calm and therapeutic environment for young people who were unwell.
- Skylark ward is for the treatment of eating disorders. It is located on the top floor of the building, accessible only by stairs. This meant that there was a risk that patients might use the stairs to exercise excessively or, conversely, might actually become too unwell to use the stairs.
- We identified a number of concerns and areas in which the provider group's complaints policy was being inconsistently applied. This included hospital director involvement and sign off of final letter; dissemination of learning; recording of concerns on the electronic complaints system; explanation of the process to the complainant in the final letter; and objectivity and independence of the complaint investigator.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We identified serious failings in relation to the recording, monitoring and and reporting of incidents. We found that poor

and inaccurate recording and reporting of incidents, lack of senior oversight and inconsistent investigation meant that the provider could provide appropriate assurance that incident data was accurate and reflected the actual number or detail of incidents, or the current risks within the service. It also meant that potential trends or near misses might not have been identified.

- We found that the service's risk register did not have clear action plans in place to mitigate the risks identified. Additionally, we saw no evidence to demonstrate that the risk register had been reviewed and updated. Some items had been on the risk register since 2012 and it was not clear what actions were in place to address the concerns highlighted. It was not clear how the senior team, or the Board, could assure itself that these risks were addressed effectively and with the appropriate urgency and focus.
- The provider's quality improvement lead weekly incident reports indicated that a number of concerns had been highlighted, internally. These concerns related to the detail, quality and completion of incident reports. However, the provider's weekly incident reports had not identified potential issues in relation to the management of incidents. They had also not identified a sizeable number of moderate and serious incidents that required further investigation.
- Clinical governance committee (CGC) minutes contained insufficient detail. They gave very little commentary, contained no outcomes or clear sense of deadlines, and there was no thematic analysis or "so what?" questions and answers. Further, no clear learning was recorded.
- The provider's own figures showed that use of restraint in response to incidents, at Southampton Priory, was noted to be higher than the Priory Group's own monitoring threshold. Clinical governance meetings were not effective forums within which incidents involving restraint and physical intervention were effectively monitored.
- A low staff sickness figure was in marked contrast to the figure supplied for staff turnover, which indicated that 38% of staff had left the service in the previous 12 months. The high staff turnover indicated potential issues in relation to staff satisfaction and morale, and this required further investigation by the provider.
- At the time of inspection, the fourth hospital director, since December 2014, had been in post for six weeks. A new CAMHS consultant was due to take up post in December 2015. The site's risk register had identified the lack of substantive hospital

director and CAMHS consultant as increased risks. We found there was reduced senior and clinical oversight at the service, and that the provider was aware of increased risks for serious incidents associated with CAMHS wards.
- Staff were offered insufficient opportunity to give feedback on services and the systems and processes for staff engagement did not seem sufficiently robust. There was no evidence of formalised staff consultations taking place in the last two years.
- Some staff were not sure about the organisation's values and vision and told us they felt a little isolated from the wider company.

However:

- When we returned to check that improvements had been made following our inspection, we found that the new hospital director had significantly improved governance processes and management of incidents. These systems had been established and will require continued monitoring and oversight to ensure they are embedded effectively.
- Senior staff we met with were aware of and in tune with the provider's visions and values. Staff we spoke with on all of the wards knew who the local senior managers were and knew and about the newly appointed new hospital director.
- The majority of staff were up to date with their mandatory training and received regular supervision. A significant number of staff had not received annual appraisals, but we were assured that most of those were staff that had not yet worked at the service for 12 months and so were not yet due an appraisal.
- At a local level, ward managers were highly thought of by their staff teams and were able to lead with appropriate authority.
- The newly appointed hospital director demonstrated a clear understanding of the governance systems and processes that would be necessary to ensure quality and safety within the service. They also recognised the importance of embedding an open reporting culture and effective risk management system.
- Figures supplied to us by the provider indicated there was a low overall sickness rate of fewer than 2% at the hospital. Staff described morale as good on each of the wards. They told us they were listened to and supported by colleagues and managers, could challenge senior colleagues about clinical decisions, and they felt able to speak out if they had any concerns.
- The eating disorders unit on Skylark ward had recently obtained accreditation through the quality network for eating

disorder (QED) scheme, through the Royal College of Psychiatrists. Medical staff on Sandpiper ward told us they felt supported in undertaking research and making improvements to the service.

- The newly appointed hospital director was extremely positive during discussion and talked enthusiastically about improving processes and systems at the hospital for the benefit of patients. We were encouraged that they would take a key role in making necessary changes to drive wider long term improvement in the quality of service provision.

Summary of findings

Information about the service

The Priory Hospital Southampton is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse;
- Assessment or medical treatment for persons detained under the Mental Health Act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

A newly appointed hospital director was in post at the time of our inspection who had not yet registered with CQC.

The hospital provides therapeutic and recovery focused residential treatment as well as day care and outpatient services. The hospital also provides specialist inpatient services for children and adolescents.

There are three wards at the hospital, each of which we visited as part of this inspection:

Kingfisher ward

Core service provided: Child and adolescent mental health wards

Male/female/mixed: mixed

Capacity: 12 beds

Sandpiper ward

Core service provided: General psychiatry, and addictions and treatment

Male/female/mixed: mixed

Capacity: 17 beds

Skylark ward

Core service provided: Eating disorder

Male/female/mixed: mixed

Capacity: 11 beds

We last inspected the service in November 2013. There were two compliance actions against the service following that inspection:

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 – Consent to care and treatment;

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 – Care and welfare of people who use services.

Our inspection team

The inspection was led by:

Team Leader: Inspection Manager Kirsten Watson, Care Quality Commission

The team that inspected this core service comprised two inspection managers (including the team leader), three inspectors, a psychiatrist, a psychologist, three specialist mental health nurses, an approved mental health practitioner social worker, two Mental Health Act reviewers (MHARs), a pharmacist and a governance specialist.

Why we carried out this inspection

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

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How we carried out this inspection

To get to the heart of 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 and asked a range of other organisations for information and feedback.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environments and observed how staff cared for patients;
- spoke with 11 patients who were using the service;
- spoke with the provider's director of quality, the recently appointed hospital director, the deputy hospital director and the managers for each of the three wards;
- spoke with 20 other staff members, including doctors, nurses, health care assistants, an occupational therapist, a psychologist and a social worker;
- spoke with an independent advocate;
- attended and observed two hand-over meetings and two multidisciplinary meetings;
- collected feedback from patients on comment cards, of which 36 of the 40 comment cards received were from Kingfisher ward;
- looked at 17 care and treatment records of patients;
- carried out checks of the medication management on the wards; and
- considered a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 11 patients across the three wards during the inspection. We also received 40 completed comment cards from patients, but were unable to determine the exact number of different patients who had submitted forms. The majority of forms were collected from Kingfisher ward, where 36 individual forms were submitted. Four additional forms were collected from elsewhere in the hospital.

Patients we spoke with during the inspection were generally positive about the care and treatment they received and about the hospital's staff and environment.

Patients on Sandpiper ward told us staff listened to them and that staff treated them with respect. They told us they were made to feel comfortable by staff and had no problems approaching staff, who they described as friendly. They also said nurses were available to speak with during the day but sometimes at night, they were not always available. Patients said they were involved in decisions about their care and treatment, were able to discuss any issues with an allocated staff member who understood their individual needs. They told us they were routinely offered copies of their care plans and confirmed they had been involved in the planning of their own care when they wanted to be. They told us they had confidence the ward manager and other senior staff would take their complaints seriously.

Feedback from patients on Skylark ward was more mixed. They told us that staff were usually respectful and polite and that there were regular community meetings where they could give feedback. However, they also reported that some staff did not always knock the door before entering the bedrooms. One patient also told us they found it difficult to approach staff that they do not know and having unknown staff on the unit can make it feel unsettled. One patient also gave specific examples of how they thought staff had treated them unequally or in a way that had made them feel degraded to some extent. Conversely, one patient also told us it was better than other inpatient units they had been on and another patient said that some staff really went 'out of their way' to support them.

Patients on Kingfisher ward we spoke to during the inspection were generally positive about their experience on the ward. They confirmed they were able to have

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regular one to one time with staff as requested or care planned. They told us they were allocated one to one time with named staff each day, which they found to be helpful. One patient on Kingfisher ward told us they would like to be a bigger part of the weekly ward round meetings, rather than just joining towards the end of the meeting after all the 'professionals' had met. Three patients on Kingfisher ward told us they thought the activities provided were good, and that they were encouraged to attend different group activities. However, a male patient on Kingfisher ward told us they felt the activities provided were geared more towards female interests and they would like a greater variety of activities including different trips out.

We received a very broad spread of feedback on the 40 feedback forms we collected, ranging from very positive, complimentary to negative, and critical. The majority of feedback forms we gathered were from Kingfisher ward.

About two thirds of the feedback forms collected were either negative or critical in nature. Some named specific staff, and gave examples of when a member of staff's behaviour towards patients had been perceived as being patronising or rude. There were multiple comments about one member of staff in particular, and we received comments about them from patients and other staff members during the inspection. We raised this with the ward manager at the time and they took immediate and appropriate action to address the concerns raised regarding that individual.

About a third of those contained either positive or neutral comments, or most of the positive comments referred to examples of compassionate care from named staff. Feedback from one person was that the staff were very caring and that they left the hospital feeling very happy. A relative of one of the patients on Kingfisher ward said they thought the standards of care were very high and that it was a safe environment. They said the staff were very caring and professional.

Good practice

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must take appropriate steps to ensure the risks associated with ligatures and ligature points are effectively mitigated across the hospital.
- The provider must take steps to ensure risks to patients are identified, assessed and monitored consistently on each ward, and that action plans in assessments and care plans are updated and contain sufficient detail to enable staff to mitigate effectively those risks.
- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding, incident recording and reporting, and the governance of the service. These concerns have been addressed in detail through a separate process of enforcement.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should carry out a detailed review of the use, level and monitoring of restraint and rapid tranquilisation at the hospital, with particular attention to their use in the treatment of young people on Kingfisher ward.
- The provider should review the form of patient care plans, to see how their consistency could be improved and to consider how they could be more patient focused. The provider should also evaluate potential risks associated with the use of dual paper and electronic care records.
- The provider should assure itself that all patients are given sufficient support and opportunity to be fully involved in the planning of their own care.
- The provider should consider ways in which the hospital could move towards greater medicines optimisation for patients.

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- In light of some of the feedback we received from patients, the provider should look at the systems in place for gathering and responding effectively to patient feedback as to the quality of service provided.
- The provider should investigate and carry out further analysis to understand why staff turnover was so high, and why so many staff had left or moved on in such a short space of time.
- The provider should review the incident alarm system, to ensure that not only is it effective, but that it also does not cause unnecessary distress or disruption on other wards or detract from the therapeutic environment.
- The provider should ensure that staff are given sufficient opportunity to input to the future development of the service and engaged fully with the organisation's vision and values.

Priory Healthcare Limited

The Priory Hospital Southampton

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Priory Hospital Southampton	The Priory Hospital Southampton

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. We reviewed adherence to the Mental Health Act (MHA) during our inspection and found the following:

- Staff told us that there were usually between 6-9 detained patients at the service, but that recently this had reduced. At the time of our visit there was one person detained under the MHA on on Kingfisher ward and one person on Sandpiper ward.No patients on Skylark ward were subject to restrictions under the MHA at the time of our inspection.
- We saw evidence in records that the wards inspected as part of this inspection adhered to the Mental Health Act (MHA) and the associated Code of Practice. We reviewed the paperwork in relation to the two detained patients, which confirmed both patients had been lawfully detained. Their section papers were present and correct, and approved mental health professional (AMHP) reports were on file as required. The AMHP reports contained evidence that the patient's nearest relative had been consulted in each case. We saw evidence that both patients had been given relevant information by staff about their rights upon first detention and then on a regular basis, and that their level of understanding had been recorded. There was evidence that both patients had been given a full physical health check upon admission. Both patients had also been informed of their right to see an independent mental health advocate (IMHA). One of the two patients was in receipt of section 17 leave and their associated paperwork was in order.
  The records contained evidence that each detained patient's responsible clinician had assessed their mental capacity to consent to treatment for mental disorder at first administration of medication.
- We found there were effective systems in place to ensure adherence to the MHA. The service's MHA administrator was available to support and give necessary guidance to staff, and to ensure the provider's

legal obligations were met. A checklist was completed when receiving a new detained patient. Appropriate filing, monitoring and controls ensured all relevant MHA paperwork was maintained and available to staff as needed. The provider had recently established a MHA network, which provided valuable central support for MHA administrators, and a senior independent consultant provided supervision of the administrator on a local level.

- The new MHA code of practice was available on all wards and online. Staff spoken with confirmed they had received training in the MHA and that relevant refresher training was held for both nurses and health care assistants.
- Patients had access to independent mental health advocacy and staff were clear on how to access and support engagement with advocacy services to obtain independent support for all patients on the wards as required. We saw evidence that patients detained under section accessed advocacy support as required. We spoke with an independent advocate from one of the two organisations who worked with the provider and who was on-site during our inspection, and they confirmed they were a regular visitor to the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward managers and senior staff demonstrated understanding of the MCA and awareness of responsibilities regarding mental capacity and consent. We saw some evidence that, in line with legal requirements, mental capacity was assessed and recorded appropriately on a decision-specific basis about significant decisions affecting people who potentially lacked mental capacity.
- Care records viewed contained mental capacity assessments and records of consent to treatment or care. For example, for the two patients detained under the MHA on Kingfisher and Sandpiper wards we saw good evidence of mental capacity assessments regarding treatment and placements. We also saw recorded evidence of best Interests discussions and decisions recorded regarding both of these situations. We looked in detail at care records for seven different patients on Sandpiper ward and saw good evidence of people having given informed consent to treatment; and, when necessary, patients' mental capacity to consent had been properly assessed and recorded by staff.
- We identified a gap in relation to the confirmation and recording of who had parental responsibility for one young person on Kingfisher ward. The patient's grandparent was recorded as next of kin, and they had signed a consent form. However, it was not recorded what the grandparent's legal status was or who had parental responsibility. However, in the records for another young person on the same ward we found a greater level of detail to demonstrate that appropriate processes had been followed. A consent to share information form had been completed which explained clearly what the young person had given consent to and with whom their information was to be shared. The consent to treatment form included a clear account from a doctor that they had assessed Gillick competence in relation to the patient's understanding of their admission, treatment and their illness. Gillick competence as a concept came from a legal case which considered whether doctors should be able to give specific healthcare advice or treatment to under 16-year-olds without parental consent. It has since become more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Young people who are Gillick competent can make decisions regarding their care and can give consent to treatment, even though their parents do not agree. Children aged sixteen and over are usuallypresumed to be Gillickcompetent, but children younger than sixteen can also be deemed as Gillick competent. The patient and a parent had signed the consent form. A mental capacity assessment was seen which referred to Gillick. This was clearly recorded on a detailed form, fully completed and with evidence regarding the patient's impairment and mental capacity.
- Staff told us that there were local procedures for deprivation of liberty safeguards (DoLS); however, in practice they rarely needed to apply for people to be

detained under DoLS due to the particular patient group in the hospital, which was a mix of voluntary patients and people detained under section of the MHA. Prior to our visit, between April and June 2015, a DoLS application had been made in respect of a patient on Sandpiper ward. However, this had been appropriately assessed and then rejected by the local authority assessing team. At the time of our visit, no patients were subject to restrictions under the Mental Capacity Act (MCA). We were assured that if a person were required to be detained under the MCA DoLS, the service's Mental Health Act administrator would oversee the appropriate administration of this.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean ward environment

- Due to the physical internal structure of the hospital, which was housed in a listed historical building, the layout of wards did not allow staff to observe easily all parts of the wards. This presented different degrees of risk to patient safety, according to the ward and patient group. On Skylark ward, the ward consisted of a corridor, with bedrooms at both ends and the office, lounge and kitchen towards the middle of the unit. Observations of the ward were not possible from the office.Two bedrooms had been refurbished, which were the only two rooms on the ward in which the doors had vision panels that could be opened to observe inside or closed to allow privacy. It was not possible to observe inside the bedrooms that did not have viewing panels in doors unless the doors were opened. Staff had to access all bedrooms to complete nighttime observations and used a torch to do this. As there was no discreet lighting available that would allow observation from outside the bedrooms, this also included the refurbished rooms. At Sandpiper ward, the layout enabled staff to observe the bedroom corridors from the nurses' station. Lounges and communal areas were only visible from the doors of those rooms.There was a closed circuit television (CCTV) camera at the end of the ward away from the main entrance, which was monitored by reception staff rather than nurses. At Kingfisher ward, there were multiple blind spots and lines of sight were not clear to all sections of the ward, including some of the bedrooms. Measures taken to mitigate the risks this posed included staff observation and walk arounds, and extensive use of CCTV monitoring throughout the ward. We found it was appropriate, in line with the level of risk to patients on the ward, that there were viewing panels in each of the bedroom doors.
- We identified multiple ligature points at each of the three wards. A ligature point is an environmental feature or structure that is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. The ligature points identified during our visit included fittings in bathrooms, and handles and hinges on wardrobes and doors. The risk associated with ligatures differed, again according to the ward and patient group.At Skylark ward, all of the bedrooms had ligature risks such as doors and taps. We saw an up to date ligature assessment that identified the ligature risks and said they were to be managed by individual patient risk assessments contained in the electronic patient record. However, in the five patient records we reviewed we did not see any mention of ligature risks in the patients' risk assessments. On Sandpiper ward, a current ligature risk assessment detailed risks such as door closures and handles. Extensive work had been undertaken to replace and remove ligature points within patient bedrooms and ensuite bathrooms. The four bedrooms adjacent to the nursing station had observation panels in the door, which allowed for patients who were identified as at greater risk of ligatures to be monitored closely. A risk assessment had been undertaken by the ward manager earlier this year, and identified that remaining ligature risks were to be managed by staff observation. At Kingfisher ward, patients had access to rooms, including bedrooms, with ligature points. The provider in its health and safety assessments had identified these risks.
- Staff told us that the way that ligature risks were managed was through observation and monitoring. However, we found the processes in place did not successfully mitigate the risks identified. This was exacerbated by ineffective governance structures and a poor culture and understanding of risk. We found evidence in records viewed and in the information supplied to us by the provider before and after the inspection that there had been a significant number of incidents involving ligatures in the previous 12 months. We saw first hand during our inspection that some of the patients on Kingfisher ward were at particularly high risk of ligature, and did in fact carry out ligature attempts during our visit. In light of the high level of risk of harm to patients on Kingfisher ward from ligatures and the high number of ligature incidents, we were not assured that the provider had taken effective steps to address the risk of ligatures on the ward.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The hospital did not comply in full with relevant national guidance on same-sex accommodation at the time of inspection. Bedrooms were single occupation with ensuite bathrooms. This meant that in line with the 2015 revision of the Mental Health 1983 (MHA) Code of Practice, The manager of Sandpiper ward showed us the ward's separation in to male and female wings; however, we saw that three male patients had been placed in the female area. Staff spoken with did not feel this presented a risk, as the rooms were located next to the nursing station. However, the location of male patients in the female wing was not in response to a 'clinical emergency,' as there were spare beds available on the ward at the time of our visit which would have allowed for the full separation of male and female bedroom areas.
- The clinic room at Skylark ward was very small and did not have an examination bed. This meant that physical examinations of patients generally took place in their bedrooms. Resuscitation equipment was kept in the ward office, but there was no sign on the office door to indicate that the equipment was kept there. Staff put up a sign to rectify this while we were on site. All equipment was clean. Medical devices including the defibrillator were overdue routine maintenance and calibration checks, but we were shown evidence that a date had been scheduled for these checks to take place. There was a fully equipped clinic room on Sandpiper ward, which also served other areas of the hospital. It was recorded in the clinic room folder that equipment had all been checked and cleaned weekly. All medical devices had recently been portable appliance test (PAT) tested and were in working order. The medication refrigerator was locked and at the correct temperature. We checked the emergency bag and found the equipment and medicines it contained were all in date. We checked the resuscitation equipment on Kingfisher ward and it was in good working order. Emergency medicines were all in date and kept appropriately in a sealed container.
- We found there was an appropriate standard of hygiene and cleanliness at each of the three wards. The wards had good quality furnishings, had been well maintained and were in a good state of repair. There were dedicated housekeeping staff for each ward, and patients confirmed that the wards were generally kept clean and tidy.
- Staff carried out a range of environmental, health and safety checks, and risk assessments on each of the wards. These covered risks associated with the environment, controlled substances, escorting young people in the grounds, nursing people with infectious diseases, and the safe disposal of medicines. Assessments identified the hazards, broke down the level of risk, and included further actions and controls required. Alarm or call systems were available in each room for patients and the majority of front line staff carried personal alarms. One member of staff we spoke to on Skylark ward did not carry an alarm, but they told us they did not believe they would be in a situation where they would need it

Safe Staffing

- The provider's staffing 'ladder' tool had been used to identify how many staff should be on duty in relation to the number of patients. We checked previous staff rotas and confirmed that staffing figures were usually at the established figures for each of the wards. On Skylark ward, one qualified nurse and three health care assistants worked across the 12 hour long day shifts. Staff from other units in the hospital, usually Sandpiper Ward, covered any unfilled shifts on Skylark's rota, and we did not see any unfilled shifts when we reviewed the rota. On Sandpiper and Kingfisher wards, there were usually two qualified nurses and three health care assistants on each ward during the daytime. At nights, there was a qualified nurse and two health care assistants on each ward. The ward manager on Sandpiper ward told us staffing numbers had been set historically and were currently under review.We saw the numbers of staff on duty matched those indicated by the rota.
- According to information supplied to us by the provider prior to our inspection, the service had an overall staff vacancy rate of 40% as of July 2015. A mix of bank and agency staff was used in varying amounts on each of the wards to cover any gaps on shifts resulting from the vacancies. Ward managers told us that they used regular bank and agency staff who were familiar with the wards and patients' needs. Bank or agency staff covered 46 shifts in the three-month period 01 April to 31 June 2015 on Skylark ward. Although they used mainly regular

bank and agency staff, one patient did tell us that they felt uncomfortable when new male bank staff were used. On Kingfisher ward there was greater use of agency staff at night.

- Night shift staff on Skylark ward were supplied and managed by Sandpiper ward, and different staff were allocated to Skylark ward each night shift when they came on duty. Staff and patients told us this affected the consistency of staffing. A patient also told us they found it difficult to approach staff that they did not know and that having unknown staff on the unit could sometimes make it feel unsettled. Skylark ward was due to take control of its own staffing, which would likely address the problem of consistency, but a final date for this had not been set at the time of our visit.
- Managers and senior staff on each of the wards told us they were able to alter staffing levels in order to meet the needs of the patient group.The ward manager on Kingfisher ward, for example, told us that staffing was generally sufficient, but that there was flexibility with the provider and they were able to request additional staff if required. Other staff on the ward confirmed this to be the case. One member of staff told us that staffing had been an issue previously, but now they just had to speak up and could get extra staff if needed. They told us staffing levels were such that, "You have enough time to spend with people." Staff spoken with at each of the the three wards told us they thought the staffing level on the wards was sufficient to safely and effectively meet the different needs of patients.
- During our visit, we observed sufficient staff were present in communal areas of wards when patients were present. However, patients on Kingfisher ward told us that on some days there were many staff out on the ward, but on other days they were less visible and "huddled" in the office. They gave an example of how this had been a problem during one incident between two patients, as there had been no staff around to intervene. We were unable to confirm this. Staff and patients we spoke with on the three wards told us activities were not cancelled due to lack of staff. Patients also confirmed they were able to have regular one to one time with staff as requested or care planned. They told us they knew whom their named nurse was and who was allocated one to one time with them on the board each day, but could approach other staff if preferred. Patients told us they thought it was good that they were allocated staff each day, which they found to be helpful.
- There was adequate medical cover available day and night, and a doctor was able to attend the wards quickly in an emergency. Consultant medical staff were on duty each day and a resident medical officer provided out of hours cover. We saw the rota to confirm this cover was in place.
- Figures supplied by the provider prior to the inspection indicated the majority of staff were up to date with their mandatory training. The rates varied, but showed completion rates of between 80-90% across different wards and teams at the service.

Assessing and managing risk to patients and staff

- We looked at 17 patients' care records across the different wards we inspected. We found that although risk assessments had been carried out for every patient on or soon after admission and were present in each of the records inspected, they varied in quality and effectiveness. We identified a number of gaps, errors and weaknesses in the service's assessment and management of risk. We found that the risk assessments in the records of patients on Kingfisher ward contained insufficient detail. For example, one patient had a recorded risk that they were 'vulnerable to exploitation'. It was not recorded anywhere in the patient's notes why they were vulnerable to exploitation, from whom, what the exploitation was, where the identified risk had come from and, most importantly, how it was to be managed. Another recorded risk was risk to them as they suffered from a specified severe and enduring mental disorder. Again, it was not recorded anywhere in the patient's notes exactly what the risk was and how the risk was to be managed. The patient was on 15-minute observations, but the records did not detail exactly for what they were being observed. In one patient's records a risk assessment had changed the level of risk from high to medium in June 2015, but it was not clear from the records how or why this decision was reached. In addition, the person was identified as being at risk of suicide risk on one date in June 2015, but no longer at risk of suicide two days later. There was

no explanation of what had changed to remove the risk. In the records for one patient on Sandpiper ward, the risk assessment referred to a history of self-neglect, but there was no further mention of anything regarding this elsewhere in the care plan. Another patient's risk assessment and care plan identified a risk of falls, but there was no appropriate falls assessment present in either the paper or electronic notes for the patient. We raised this with the nurses on the ward at the time and they agreed that it needed to be reviewed.

- We found there were no blanket restrictions in place and informal patients were free to leave the hospital at will. The only exception to this was when an informal patient was considered by staff to be at significant risk if they left the hospital unescorted. Staff told us that if this situation ever arose, they would try to persuade the vulnerable patient to remain at the hospital or, ultimately, would seek to hold them there by following an appropriate legal process.

- Staff and managers on the three wards told us that the use of restraint had decreased in the last 12 months, that the focus was now much more on de-escalation and that restraint was only used as a last resort. However, we identified a number of concerns in relation to the use, level and monitoring of rapid tranquilisation of patients at the service, specifically vulnerable younger people on the CAMHS ward. We identified serious concerns in relation to the provider's systems and processes for assessing and managing risks to patients and staff, and this included the use and monitoring of both restraint and rapid tranquilisation.

- For example, staff were not recording all instances of restraint and the provider was not sufficiently robust in its analysis and interpretation of restraint and rapid tranquilisation at the service. When the use of restraint had been recorded by staff, in some instances the records contained insufficient detail or inaccuracies. This in turn meant it was not possible to get an accurate or reliable representation and understanding of the levels of restraint and rapid tranquilisation that were used. Use of restraint is monitored as part of a set of key performance indicators for services, using a `25% of incidents` threshold, this includes all types of restraint, for example full holds or guiding someone away from a situation. The provider's own monitoring threshold showed an upward trend was noted on Kingfisher ward via the restraint threshold monitoring and a plan was agreed with the service to monitor this. However, this plan lacked the detail and depth necessary to give adequate assurance that it would identify if there were a more serious concern with the numbers of restraints taking place. We found that the provider's forums where discussion of rapid tranquilisation and restraint should have taken place did not provide effective oversight, which in turn meant that appropriate steps were not taken to address potential issues identified by those high figures. There was no detail recorded in the minutes to governance meetings that incidents involving restraints were reviewed or discussed within such forums. Our concerns are covered in detail in the separate enforcement action we have taken against the provider regarding this.

- Staff we spoke with showed a good understanding and knowledge of safeguarding procedures. There were designated children`s and adult safeguarding leads, all of whom were also safeguarding trainers. Safeguarding training was held across the site for all employees, and the level of training was adapted according to their role within the organisation. The safeguarding leads reported they received monthly telephone supervision from the regional safeguarding lead, and that they felt well supported to undertake their roles. There were regular regional safeguarding meetings, the last one in May 2015.

- There were safeguarding processes in place for staff to report and record safeguarding concerns. There were safeguarding folders on each ward, and an overarching safeguarding log, which recorded all concerns raised, and any actions taken, for example, a referral to the local authority or police. However, while clinical governance meeting minutes reflected that safeguarding updates were given, we found there was not any senior oversight of the safeguarding log to ensure that the safeguarding processes had been followed fully in all instances and that actions had been taken in a timely manner. We were concerned that some processes around reporting were unclear, for example in respect of allegations of historical abuse. We were told that such allegations would not be recorded on an incident form unless they were reported to the police, and that the service would seek advice about when to report to the police from the local authority. We found an example that reflected that timely actions had not been taken following such advice from the local

authority. The Priory Group safeguarding policy, July 2015, stated 'All safeguarding incidents and allegations of abuse will be reported on the Priory Incident Reporting System. A note will be made of whether the incident is disclosure of a historical event or whether it is a current issue.' We also noted that 12 of the current allegations noted on the local safeguarding register were not logged on the incident reporting data we reviewed. We were concerned that while there were systematic measures in place to report and record safeguarding allegations and concerns, these were not implemented consistently in line with the Priory Group safeguarding policies, which reduced internal and external oversight.

- We reviewed in detail the processes and systems related to the management of medicines across the three wards. We identified the scope for improvement to the systems for and approach to medicines management. However, overall, we found the processes and systems in place were adequate to ensure the safe management of medicines.

Track record on safety, reporting incidents and learning from when things go wrong

- We identified serious concerns in relation to the provider's systems for reporting incidents and learning from when things go wrong. We were concerned that inconsistent and inaccurate recording and reporting of incidents, lack of senior and organisational oversight, and inconsistent investigation of moderate and serious incidents meant that the provider could not be assured that incident data was accurate and reflected the actual number or detail of incidents, or the current risks within the service.It also meant that potential trends or near misses might not be identified to learn from and prevent future incidents. The failings identified meant it was subsequently extremely difficult for the inspectors, local commissioners and the provider itself to get a clear understanding and accurate assessment of the service's track record on safety. We have taken separate enforcement action against the provider regarding these issues.
- Staff spoken with were able to tell us what sorts of events they would formally record and report as incidents, that they would always record who was involved, what happened and why it happened. Senior ward staff completed incident forms initially, and all incident forms were then reviewed by an appointed member of the local senior management team. Staff felt confident about reporting incidents, and told us they reported incidents using the electronic system, which was available across all the provider's hospitals.
- Despite this, we were concerned there was not an open culture of incident reporting at the service. For example, we noted that staff had been directed to record multiple incidents on single incident forms for patients, or not to record `minor` incidents on incident forms.From discussion with senior staff, we found there was a lack of clarity around the use of incident reports.Staff felt that data was often duplicated, or there may be multiple `low level` incidents for one person, and that completing individual incident reports was not considered the most effective use of time and would impact on `care giving` time. This had the potential to affect how risks were identified and subsequently recorded across the service.
- We found examples of multiple incidents recorded as a single entry on an incident report. For example, multiple ligatures and restraints throughout the day with one individual were recorded as having taken place over a 9 ½ hours period but were recorded as a single incident report on the electronic system. Recording incidents in this way affected the accuracy of actual numbers of incidents collected and recorded, and potentially showed considerably fewer incidents than had actually occurred within the service. It also reduced the provider's ability to carry out essential oversight of trends.
- We found evidence that a significant number of the electronic incident forms weren`t completed accurately, for example information boxes weren`t always filled in and ticked correctly, which meant that subsequent higher level incident reports would not pull through all of the relevant issues. For example, we requested a spreadsheet detailing `incidents involving staff assaults`, and the spreadsheet showed eight staff assaults recorded over a period of several months.However, from our review of individual records we identified there were more incidents involving assaults on staff than this. We identified similar concerns in relation to key indicators of safety such as use of restraint and rapid tranquilisation. From reviewing the incident reports and other data provided,

we found numerous examples of poor, incomplete or inaccurate recording of incidents. Incident forms and summary spreadsheets lacked the detail required to enable a clear picture of what actually happened, for example, how many restraints took place and for how long, who was involved, what medication was given via what route, accurate timelines, the outcome and then who was informed.

- Some incident reports contained identical information about actions taken with different patients, at the same time. It would not have been possible for these interventions to happen at exactly the same time, involving the same staff with different patients; therefore itwas not possible to gain an accurate overview of what happened and when from the incident report.
- Incident reports did not always contain sufficient detail required to give a good understanding about what happened. For example, in one incident report we reviewed stated that the person ligatured four times, 'in their bedroom, refused to remove [the ligature by themselves], removed by staff.' The form was ticked for `physical intervention` used, however, there was no further detail about this, or any other aspect of the incident, on the incident report. The problems identified in relation to the recording and reporting of incidents meant that the provider could not be assured that data was accurate and reflected the actual number of incidents or the current risks within the service.
- Providers have a statutory duty to notify the Care Quality Commission (CQC) of a range of events or occurrences. These include, for example, allegations of abuse and incidents reported to or investigated by the police. Following our post inspection analysis of incident data for the previous 12 months, it was identified that provider had not notified us of a number of such incidents. Following communication with local NHS England commissioners, it was found that there had been incidents at the service that they had also expected to be notified of but had not been. The failure to notify CQC and NHS commissioners of all incidents, in line with statutory obligations, meant that key agencies had not been able to get a clear understanding or accurate evaluation of risks and overall safety levels at the service.
- Staff we spoke with told us they met together for discussion after serious incidents and that debriefing sessions were organised for them after such events.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Care records showed that comprehensive examinations of people's physical status and assessments of their mental health needs were carried out at or soon after admission to the hospital. Care records for patients on Sandpiper ward showed how physical examinations of patients had been undertaken by medical staff upon admission. We also saw physical health problems were subsequently monitored and dealt with appropriately. We saw evidence that care and needs assessments were updated and amended following admission to the ward. Similarly, in the five care records we reviewed for patients on Skylark ward, each included an assessment of the patient's physical needs and then care plans to address any identified care needs. Similarly, thorough physical and mental health needs assessments had been carried out and recorded for patients on Kingfisher ward.
- We looked at 17 patients' care records in total across the three wards. We found there was some variance in quality and identified gaps and inconsistencies in some care plans. For example, the risk assessment for one patient on Sandpiper ward identified a history of self-neglect, but there was no mention of anything regarding this in the care plan. Similarly another patient's risk assessment identified a high risk of falls, yet there was no falls assessment present in the paper or electronic care notes. The nurses spoken with at the time agreed that this needed to be reviewed. We also found the care plans on Sandpiper ward in particular were not sufficiently patient centred, but written predominantly from a professional's point of view.
- Care plans and confidential records were stored securely and available for staff use as appropriate. None of the staff spoken with raised concerns as to difficulties or specific issues with completing and updating care records. We did identify concerns, however, in relation to the existence and use of parallel electronic and paper based records. On Kingfisher ward paper and electronic notes were used, with paper being used to record assessments and care plans on a patient's admission and the information being then transferred over to the electronic system. In one patient's records, we identified differences between the electronic and paper records and gaps on both. For example, the electronic records had the name of the member of staff who had completed them and the patient's risk level was recorded as red and high. This section of the care record was not completed on the paper record and there was no name to identify which member of staff had completed it. There was a risk that if staff referred to the paper record, they would not identify appropriately the patient's level of risk. On Sandpiper ward staff were also using paper and electronic notes. We saw instances where the written notes contained more detailed and up to date information concerning the patient's condition and progress, but they had sometimes not been uploaded electronically in a timely manner. This meant there was a risk staff may refer to out of date electronic care records.

Best practice in treatment and care

- Processes and systems for the management of medicines were looked at in detail by both a specialist pharmacist and a specialist nurse during our inspection. We found that wards generally worked within National Institute for Health and Care Excellence (NICE) guidelines in respect of the prescribing and management of medication. The pharmacist visited wards weekly and carried out checks to ensure prescribing was within guidelines. However, we found that there was scope for greater emphasis on effective medicines optimisation. For example, there were no formal patient involvement sessions with the pharmacist and we saw no evidence that patients were encouraged to seek information or to discuss medicines with them. The Royal Pharmaceutical Society state that medicines optimisation is about: 'ensuring that the right patients get the right choice of medicine, at the right time;' and that 'by focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety… encourage patients to take ownership of their treatment.'
- Patients on the three wards were offered a variety of different psychological therapies. Patients could access psychological therapies and activities as part of their treatment. On Sandpiper ward therapies, which included cognitive behavioural therapy (CBT), were delivered in both one-to-one and group settings. For

alcohol addiction the 12 step process, which requires total abstinence, was followed. A patient on Skylark ward advised us that they were currently unable to receive CBT as the person responsible for this work had left and the hospital was still looking for a replacement. During our visit to Skylark ward, we saw all patients attended therapy sessions and in the multi-disciplinary meeting we observed therapy options for the patients were discussed. At Kingfisher ward a family therapist worked two days a week, and a clinical psychologist usually worked full time on the ward. Eye movement desensitisation and reprocessing (EMDR) therapy was provided once a week. An occupational therapist did sensory therapy and worked with patients to look relaxation techniques and at alternatives to self-harm. Staff told us the variety and amount of therapies provided on the ward had noticeably increased. However, one patient told us they wanted talking therapy, but claimed they had been told they could not have such therapy. Another patient told us they had been on the ward for nearly two months, but had not yet received any therapy. They had attended group sessions run by the occupational therapist, however, and were due to start some one to one anxiety work. A senior member of clinical staff acknowledged that access to self-help therapies was an area for improvement, particularly as patients often had not had that sort of support at primary care.

- Care records contained evidence that patients had access to physical healthcare, including the intervention of specialists, when needed. Emergency healthcare was undertaken by the NHS for patients requiring urgent physical or mental health intervention.
- Staff took part in a range of clinical audits. These included audits of care records, safeguarding, prescribing, and relapse prevention. Audits of the Mental Health Act and Mental Capacity Act were carried out as part of the provider's range of audits. Independent managers carried out audits and we were told they were about to carry out an audit of how many people were discharged after tribunals or manager's hearings.

Skilled staff to deliver care

- Wards were supported by a wide range of staff including medical, psychology, occupational therapy and pharmacist. Due to the fact patients came from a wide geographical catchment area, staff also liaised with each patient's relevant local social services staff, depending on which local authority they lived in.
- We found that medical, therapy and senior nursing staff were experienced practitioners. There were appropriate policies in place covering medical revalidation, staff appraisal and supervision. Staff at each of the wards told us they received regular supervision and felt well supported. Ward managers told us that unqualified staff had monthly group supervision and monthly one to one supervision facilitated by external supervisors. For qualified and more senior staff supervision was provided internally. Clinical staff on Kingfisher ward told us they had weekly formal supervision with the consultant and regular informal supervision. According to information supplied to us by the provider prior to inspection, all staff who had worked at the service for a year or more had gone through an annual appraisal in the last 12 months.
- Staff spoken with told us they were able to request and receive additional specialist training if specific knowledge gaps were identified, but this was dependent on them establishing a business need. For example, staff of different roles and levels on Skylark ward had been given specific eating disorder training.
- We raised a number of concerns related to staff conduct on one of the wards, which had been brought to our attention during the inspection, and saw how the ward manager then took appropriate action to address the staff performance issues promptly and effectively.

Multi-disciplinary and inter-agency team work

- There were two handover meetings on each ward, which occurred each morning and evening at the end of 12-hour shifts. We were told that all staff coming on to shift were expected to attend the hand-overs. Staff told us that the most important pieces of information were passed on at hand-overs.
- We observed a multi disciplinary team (MDT) meeting on Skylark ward. This was well attended by different staff from the MDT. We saw that the meeting followed an appropriate agenda, which included discussion about existing patients and new referrals to the service. We observed that staff worked well together and that all staff were listened to during the meeting. On Kingfisher

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ward, a senior member of clinical staff told us that the MDT team worked well together and that the weekly ward rounds were not psychiatry led, but inclusive of all of the MDT team except health care assistants (HCA). Patients were invited to attend the MDT ward round meetings and HCAs also attended if they had a significant relationship with the patient. At Sandpiper ward each of the three admitting consultants held weekly MDT ward round meetings to discuss their patients and plan of care. In addition, monthly business meetings were held on the ward for all staff and a wider multi-disciplinary group for the whole hospital met every six weeks.

- Staff told us they felt working relationships with external organisations were generally good. However, they said it was sometimes difficult to ensure the attendance of the patient's local authority care coordinator, especially when they often worked a considerable distance away. We sat in on a care programme approach meeting on Kingfisher ward, which was attended by appropriate internal and external professionals, and observed effective multi disciplinary working. This included good liaison with the patient's home treatment team to explore alternatives to in-patient treatment, such as day care. We saw evidence of effective liaison and communication with external agencies in people's care records, such as contact with patients' GPs in relation to their admission and provisional diagnosis.

Adherence to the MHA and the MHA Code of Practice

- Staff told us that there were usually between 6-9 detained patients at the service, but that recently this had reduced. At the time of our visit there was one person detained under the MHA on on Kingfisher ward and one person on Sandpiper ward.No patients on Skylark ward were subject to restrictions under the MHA at the time of our inspection.
- We saw evidence in records that the wards inspected as part of this inspection adhered to the Mental Health Act (MHA) and the associated Code of Practice. We reviewed the paperwork in relation to the two detained patients, which confirmed both had been lawfully detained. Their section papers were present and correct, and approved mental health professional (AMHP) reports were on file as required. The AMHP reports contained evidence that the patient's nearest relative had been consulted in each case. We saw evidence that both patients had been given relevant information about their rights upon first detention and then on a regular basis, and that their level of understanding had been recorded. There was evidence that both patients had been given a full physical health check upon admission. Both patients had also been informed of their right to see an independent mental health advocate (IMHA). One of the two patients was in receipt of section 17 leave and their associated paperwork was in order.
- The records contained evidence that each detained patient's responsible clinician had assessed their mental capacity to consent to treatment for mental disorder at first administration of medication.
- We found there were effective systems in place to ensure adherence to the MHA. The service's MHA administrator was available to support and give necessary guidance to staff, and to ensure the provider's legal obligations were met. A checklist was completed when receiving a new detained patient. Appropriate filing, monitoring and controls ensured all relevant MHA paperwork was maintained and available to staff as needed. The provider had recently established a MHA network that provided valuable central support for MHA administrators, and supervision of the administrator on a local level was provided by a senior independent consultant.
- The new MHA code of practice was available on all wards and online. Staff spoken with confirmed they had received training in the MHA and that relevant refresher training was held for both nurses and health care assistants.
- Patients had access to independent mental health advocacy and staff were clear on how to access and support engagement with advocacy services to obtain independent support for all patients on the wards as required. We saw evidence that patients detained under section accessed advocacy support as required. We spoke with an independent advocate from one of the two organisations who worked with the provider and who was on-site during our inspection, and they confirmed they were a regular visitor to the service.

Good practice in applying the MCA

- Ward managers and senior staff demonstrated understanding of the MCA and awareness of responsibilities regarding mental capacity and consent.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Care records viewed contained mental capacity assessments and records of consent to treatment or care. For example, for the two patients detained under the MHA on Kingfisher and Sandpiper wards we saw good evidence of mental capacity assessments regarding treatment and placements. We also saw recorded evidence of best Interests discussions and decisions recorded regarding both of these situations. We looked in detail at care records for seven different patients on Sandpiper ward and saw good evidence of people having given informed consent to treatment and when necessary, mental capacity to consent had been properly assessed and recorded.
- We identified a gap in relation to the confirmation and recording of who had parental responsibility for one young person on Kingfisher ward. The patient's grandparent was recorded as next of kin, and a consent form had been signed by them. However, it was not recorded what the grandparent's legal status was or who had parental responsibility. However, in the records for another young person on the same ward we found a greater level of detail to demonstrate that appropriate processes had been followed. A consent to share information form had been completed which explained clearly what the young person had given consent to and with whom their information was to be shared. The consent to treatment form included a clear account from a doctor that they had assessed Gillick competence in relation to the patient's understanding of their admission, treatment and their illness. Gillick competence as a concept came from a legal case which considered whether doctors should be able to give specific healthcare advice or treatment to under 16-year-olds without parental consent. It has since become more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Young people who are Gillick competent can make decisions regarding their treatment and can give consent to treatment, even though their parents do not agree. Children aged sixteen and over are usually presumed to be Gillick competent, but children younger than sixteen can also be deemed as Gillick competent. The consent form had been signed by the patient and a parent. A mental capacity assessment was seen which referred to Gillick. This was clearly recorded on a detailed form, fully completed and with evidence regarding the patient's impairment and mental capacity.
- We were told by staff that there were local procedures for deprivation of liberty safeguards (DoLS); however, in practice they rarely needed to apply for people to be detained under DoLS due to the particular patient group in the hospital, which was a mix of voluntary patients and people detained under section of the MHA. Prior to our visit, between April and June 2015, a DoLS application had been made in respect of a patient on Sandpiper ward. However, this had been appropriately assessed and then rejected by the local authority assessing team. At the time of our visit, no patients were subject to restrictions under the Mental Capacity Act (MCA). We were assured that if a person was required to be detained under the MCA DoLS, then the appropriate administration of this would be overseen by the service's mental health act administrator.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- On our inspection visits to the three wards, we observed that staff treated people with compassion and were sincere and caring in the way they interacted and gave support. On Sandpiper ward, for example, staff engaged with patients in a respectful manner, and were discreet and respectful when discussing personal issues with them. We saw staff providing a broad range of practical and emotional support to patients during our visit. At Kingfisher ward, we sat in on a care programme approach (CPA) meeting that was attended by the patient, their next of kin and a number of staff members. We saw the attitude of the staff was very caring towards the patient; they explained well different things to them and ensured they understood what was discussed.
- The patients we spoke with in person during the inspection were generally positive about staff who they said tretd them ith kiness,dinityad respct. One patient on Skylark ward told us that they felt the ward was different to other inpatient units, as other units would discharge you if you did not meet specific targets. Another patient told us that some staff really went out of their way to give support. Patients we spoke with on Sandpiper ward told us they were listened to and that staff treated them with respect. They told us they were made to feel comfortable and had no problems approaching the staff who, they said, were friendly.
- However, feedback from patients was not unanimous and during the inspection we received some negative comments.A patient on Skylark ward felt staff did not treat them as an equal. Patients also told us that some staff did not always knock on the door before entering their bedrooms.
- We also collected anonymised feedback from patients using comment cards that had been put into sealed boxes placed at different locations in the hospital. We received the largest number of comment cards from patients on Kingfisher ward, from where we collected 36 individual cards. Although it was apparent some patients had submitted multiple comments, we identified at least eight different handwriting styles on the cards. The feedback received on the cards was mixed, but about a third of the comments were either positive or neutral. For example, named staff were singled out for praise for being caring and supportive. However about two thirds of the comments were negative. Some gave examples of when staff's behaviour towards patients had been perceived as being patronising or rude. There were multiple comments about one member of staff in particular, and we received comments about them from patients and other staff members during the inspection. We raised this with the ward manager at the time and they took immediate and appropriate action to address the concerns raised regarding that individual.

The involvement of people in the care they receive

- Admission processes informed and oriented patients to the ward and service. At Skylark ward, patients were given a tour of the ward when first admitted. Patients were then escorted on fresh air breaks in the grounds and outside the building, until staff had risk assessed that they could go out on their own. At Sandpiper ward, the ward manager told us they liked to show new patients around the different ward areas, personally, on admission. Information packs were given to all new patients to inform them about their stay and what level of service to expect.
- We saw ways in which patients were involved in the planning of their own care. For example, on Skylark ward we saw patients actively participated in their own CPA meetings. At Sandpiper ward, patients told us that they were involved in making decisions about their care and treatment. Patients at each of the wards told us they had received or been offered copies of their own care plans, and confirmed they were usually sufficiently involved when they wanted to be. Patients confirmed they were invited to attend the weekly multidisciplinary team (MDT) meetings. However, we found there was inconsistency between the three wards as to how effectively some patients were involved in the planning of their own care and treatment. For example, one patient on Kingfisher ward told us they would like to be a bigger part of the weekly ward round meetings, rather than just joining towards the end of the meeting after all the 'professionals' had met.
- Independent advocacy is a valuable tool, which can help to safeguard and give a stronger voice to potentially vulnerable people who use services. Information about how patients could access

Good

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independent advocacy and the role of advocates was clearly displayed on notice boards and available on the wards. Ward managers and senior staff were able to tell us what advocacy services were available, including statutory independent mental health advocacy. Staff told us that people were supported to access independent advocacy services if and as needed, and patients spoken with on each of the wards confirmed they either were supported by an advocate or knew the support was available to them if ever they wanted it.

- Families and carers of patients were encouraged to be involved in the ongoing process of care planning and delivery. On Sandpiper ward, we saw carers were invited to attend CPA meetings when the patient had agreed to this. We saw evidence that patients, carers and family members were involved in the decisions about the care and treatment. Families of patients on Skylark ward were encouraged to visit and a family room was available to allow confidential meetings to take place. Entries in a patient's care record showed the service had taken steps to involve their family in risk management in planning for a holiday. This had included using the internet to contact the family as they lived abroad and did not have access to a phone. We saw evidence in other patient records that staff had spoken to families after periods of home leave to discuss how it had been. On Kingfisher ward, we sat in on a CPA meeting which was attended by one of the the patient's parents. Although there was a difference in opinion between them and staff as to the patient's condition at that time, we saw that staff supported them to input to the meeting.
- We saw a number of positive ways in which patients were able to give feedback on the service they received. Regular ward community meetings gave opportunities for patients to speak up about any concerns they had and to give their feedback as to how things were done on the wards. At Sandpiper ward, for example, the community meetings took place weekly and we saw the notes from the most recent meeting had been displayed in the main lounge. On Kingfisher ward, patients gave examples of where they had been able to approach staff to feed back or raise concerns, and they were happy about how their concerns had then been dealt with. Patients were encouraged, upon discharge from the hospital, to complete a 'friends and family' questionnaire about their stay. According to information supplied by the provider prior to the inspection in their information return, patients on Kingfisher CAMHS ward also had the opportunity to provide input to monthly clinical governance meetings.
- Patients were able to get involved in decisions about their own care and the wider service provision, which included involvement in the recruitment of staff. On Kingfisher ward, we were shown the revised complaints leaflet which had been designed by patients. Staff gave other examples of how patients were involved in the choosing of pets for the ward and with decorating choices when the ward was renovated. The newly appointed hospital director was very clear in discussion with us, about the importance of patient involvement in the staff recruitment process, and stated it was something they intended to develop further. On Skylark ward, staff told us that patients were given the opportunity to show candidates around at interview and that they had provided questions to be used at interview. More recently, the provider had approached a recognised mental health charity to enable the input of the patient voice to the interview panel.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access, discharge and bed management

- The average bed occupancy across the three wards in the six months January to June 2015 was 83%. Kingfisher ward had a particularly high occupancy rate of 96%. The bed occupancy rate at Skylark had been 78% for the six months from January to June 2015. Staff told us that at this occupancy rate, the service had been able to admit patients quickly. Further, it meant that their beds could be kept available for them to return to when patients went on leave.
- The Priory Hospital Southampton accepts both NHS and private patients. Admissions for NHS patients to Sandpiper general ward were made following referrals from mental health trusts. These were reviewed by senior staff on the ward to determine the level of risk and the impact on other patients before accepting admission. Private patients accessed the service by a referral from their GP. Staff told us that should a patient's condition deteriorate and require their transfer to a more intensive facility, this was arranged through liaison with the local mental health trust from where the patient was resident. The provider also delivered psychiatric intensive care at other hospitals in the group, which could be offered dependent upon the funding agreement in place for a patient.
- Staff at Kingfisher and Sandpiper wards told us there had been a small number of occasions over the last year when a patient's discharge had been delayed. According to information supplied by the provider prior to the inspection in their information return, there had been 20 delayed discharges reported for the period July 2014 to July 2015. The provider gave us an assurance that delays to discharge were generally because of a lack of appropriate accommodation to discharge them to and patients' social situations. A senior member of staff explained to us that a small number of the delayed discharges resulted from referring teams not explaining fully at referral a patient's personal circumstances in the community, which then resulted in the patient having to remain on the ward even though they were ready for discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- The environment on each ward was clean and comfortable, and the furnishings and decoration were in good condition throughout. Each of the wards had a range of different rooms and equipment to support treatment and care. This included rooms for interviews and therapy, clinic rooms for examinations, quiet rooms and larger communal rooms for group activities. At Skylark ward, there were rooms available for therapy sessions and meetings that were in use throughout our visit. At Sandpiper ward there was a range of rooms used for activities as well as quiet rooms and lounges, which the patients had access to 24 hours a day. On Kingfisher ward, staff raised with us that that space was lacking, and that coordinating activities on the ward and family visits was sometimes difficult, meaning for example families had to use bedrooms for meetings with patients. However, patients also had the use of a bright and spacious occupational therapy suite, which was used for group activities and individual activities such as baking.
- The majority of patients on Sandpiper and Skylark wards were informal and so had free access to the extensive and attractive grounds surrounding the hospital. The staff on Skylark ward monitored patients' exercise as part of their treatment, and that meant a patient might be encouraged to remain on the ward to avoid excessive exercise or if they were upset. Due to specific safety concerns related to many of the young people on Kingfisher, access to the grounds was more limited but there was a separate enclosed outdoor space where they could go under staff supervision.
- There were quiet areas around the building, which informal patients had access to and which could be used for meeting visiting relatives and professionals. We identified a specific problem in relation to the environment on Kingfisher ward. During the first day of our inspection visit, a loud alarm went off repeatedly on the ward, which was related to incident in other parts of the hospital outside the ward. It was intended to alert staff on Kingfisher ward so they could attend to provide assistance. Each time the alarm went off, a number of staff from Kingfisher ward rushed from the ward to attend the incident elsewhere in the hospital. Combined with the loud alarm, these sudden spurts in staff activity

Good

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created a somewhat chaotic atmosphere on the ward at those times. We found this was disruptive, and not conducive to creating a calm and therapeutic environment for people who were unwell.

- On Sandpiper ward there was a telephone located in each bedroom where patients could make private phone calls. On Skylark ward, patients were allowed to have their own phone on the ward and could make calls in private in their bedrooms. However, access to telephones was more limited on Kingfisher ward and a number of patients complained to us that there was not always a private place for them to make phone calls.
- The feedback received from patients during the inspection was that the food provided was of good quality. Food was prepared by a central kitchen and served in separate dining room, which wards used at different times. On each ward, there was also a small kitchen for patients to use to make snacks and warm drinks. Patients on Skylark told us they were are able to meet with the chef and give them feedback. They told us they had a good choice of meals and the food was generally of a good quality. Due to the nature of Skylark ward, snacks for patients on the ward were controlled. Patients on the ward had cooking sessions as part of their therapy. All patients we talked to on Kingfisher ward were positive about the food provided.
- Patients had access to a range of activities. During our visit, we saw the activity schedule on Sandpiper ward was tailored to meet the needs of the patient group, and patients told us they were given a personalised activity plan. There was good access to ward based activities as well as a range of activities outside of the hospital. Activities on the plans included flower arranging, gym and walks, which took place in the local area. Patients on Skylark ward told us that access to activities away from the hospital was restricted at times when there was not a driver on duty to drive the hospital minibus. They also raised the remote, rural location of the hospital as being a factor in restricting activities they were able to do. Patients at Kingfisher raised similar concern. Three patients on Kingfisher ward told us they thought the activities provided were good, and that they were encouraged to attend different group activities including structured occupational therapy activities. Young people on Kingfisher were given a weekly allowance, which they were able to spend doing individual activities of their own choosing. One male patient on Kingfisher ward told us they felt the activities provided were geared more towards female interests and they would like a greater variety of activities including different trips out.

Meeting the needs of all people who use the service

- At each of the wards we visited, we saw there was a range of information provided for people who used services. This included information on different conditions and treatments, patient's rights, local support projects including advocacy, and how to make a complaint if they were not satisfied with the service they received. Staff we met on the ward were aware of patient's individual needs and tried to ensure these were met. This included cultural, language and religious needs. Interpreting services were available when required. We spoke with one patient who had specific religious and cultural needs, including food and prayer needs. They confirmed these specific needs were met by staff.
- The wards had been adapted to ensure accessibility for disabled people. This included flat surfaces and ramps for wheelchair users and disabled adapted toilets. Bathrooms had necessary hoisting equipment and adapted baths. Outdoor spaces were flat and pathways wide enough for wheelchair access. On Sandpiper ward there was an adapted bedroom to allow patients who used a wheelchair access. Although the building did not have a lift for patients with mobility issues, such patients were able to access the ward by the ground floor.
- We identified a specific concern in relation to the location of Skylark ward, which was on the top floor of the building and accessible only by stairs. Due to the nature of the ward, which isthe treatment of eating disorders, there was a risk that patients might use the stairs to excessively exercise or, conversely, may actually become too unwell to use the stairs. Senior staff acknowledged our concerns, and suggested that the eating disorder service's location was likely to be changed as part of a broader future re-evaluation and redesign of service provision at the site.
- The service was able to provide a choice of food in order to meet the dietary requirements of different religious

Good

Are services responsive to people's needs?

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and ethnic groups. An on-site chef enabled the hospital to meet individual religious or cultural dietary needs, and the chef was able to visit the wards to discuss dietary needs with individual patients.

Listening to and learning from concerns and complaints

- According to figures supplied to us by the provider before the inspection, the Priory Hospital Southampton had received 19 formal complaints overall in the preceding 12 months. The majority of the complaints were in relation to Sandpiper ward, about which 13 complaints were received. Five of the complaints concerned Kingfisher ward and just one of the complaints related to Skylark ward. Of the 19 formal complaints recorded four were upheld, two were referred on to the independent sector complaints service (ISCAS) and one of those complaints was upheld by ISCAS.
- Staff on Skylark ward told us that patients did make many minor complaints about day-to-day issue, but that these were dealt with on the ward by the staff at the time. If staff were unable to resolve a patient's complaint, then they would be referred to a more senior manager and taken through the more formal complaints procedure. Several patients on Kingfisher ward told us they had felt able to complain to staff about the conduct of one member of staff and that they were happy with how staff responded to those concerns.
- Patients on Sandpiper ward told us that if they had cause to complain, they were confident the ward manager and other senior staff would take their complaints seriously. Information on how to make a complaint was displayed on the ward and in the welcome packs for patients. Information on mental health advocacy (IMHA) services was also displayed, and the IMHA service would be able to give independent support to any patient who wished to make a formal complaint. Informal complaints were reported by staff and patients as being dealt with at ward level and in weekly community meetings.
- We reviewed the Priory group's complaints policy, which was the policy used locally. Based on detailed examination of four separate complaints on file we identified a number of concerns and areas in which the policy was not being consistently applied. This included hospital director involvement and sign off final letter; dissemination of learning; recording of concerns on the electronic complaints system; explanation of the process to the complainant in the final letter; and objectivity and independence of the complaint investigator.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Senior staff we met with were aware and supportive of the provider's visions and values. However, other staff were not so sure and told us they felt a little isolated from the wider company. This was attributed to the large geographical spread of other sites. Staff on Skylark ward were in the process of developing a mission statement and working on how the ward's values statement would fit with the provider group's values. Staff we spoke with on all of the wards knew who the local senior managers were and knew and about the newly appointed new hospital director.

Good governance

- The majority of staff were up to date with their mandatory training and received regular supervision. According to figures supplied to us by the provider prior to inspection, about half of the staff team had not received annual appraisals. However, we were subsequently assured that most of those were staff that had not yet worked at the service for 12 months and so were not yet due an appraisal. Although there were a number of nursing staff shortages, shifts were generally covered by sufficient numbers of staff of the right grades and experience. Staff participated in clinical audits. At a local level, ward managers were highly thought of by their staff teams and were able to lead with appropriate authority.
- As reported above, we identified serious failings in relation to the recording, monitoring and and reporting of incidents. We found that poor and inaccurate recording and reporting of incidents, lack of senior oversight and inconsistent investigation meant that the provider could not be assured that incident data was accurate and reflected the actual number or detail of incidents, or the current risks within the service. It also meant that potential trends or near misses might not have been identified. Additional quality assurance processes had not effectively identified the extent of the issue, or put in place effective action plans to address this, such as additional support and training for staff. This in turn had the potential to impact on how risks were identified, recorded and responded to across the service.
- We reviewed the service risk register, which included clinical and environmental risks. We found that the risk register did not have clear action plans in place to mitigate the risks identified. For example, none of the actions on the risk register included a timescale for implementation or review. Additionally there was no evidence that demonstrated the risk register had been reviewed and updated. Whilst some actions had been recorded, it was not clear when actions had been initiated, and targets were not identified which would if or why the level of risk had been effectively reduced. We reviewed clinical governance meeting minutes from January 2015 to June 2015. These included an agenda item for the risk register to be discussed. We noted that the outcome stated `updated`, with no detail, or that the risk register would be `reviewed in the senior management team` meeting. We requested minutes from the senior management team meetings, and were advised none were recorded. We were unable to clarify the frequency of the senior team meetings, who attended or the extent to which the risk register was discussed.
- Some items had been on the risk register since 2012 and, despite being highlighted as a continued risk for three or more years, it was not clear what action was in place to address the concerns highlighted. It was also not clear whether staff were aware of concerns on the risk register or any associated action plans. For example, the quality of care records (including care plans and risk assessments) had been on the risk register since October 2012. The mitigation plan stated, 'care plans being reviewed regularly', and this had remained a `medium risk`. In 2013 poor consultant records was added. We noted that the clinical governance meeting minutes continued to highlight concerns with records, in particular consultant records and care plans. We also identified concerns with records in this inspection. It was not clear from the risk register, with the lack of target dates and effective action plans, how the senior team, or the Board, could be assured that these risks were being addressed effectively and with the appropriate urgency and focus.
- The site risk register had identified the lack of substantive hospital director and CAMHS consultant as increased risks. This highlighted that there was reduced senior and clinical oversight at the service and that the organisation were aware of increased risks for serious

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incidents associated with CAMHS wards. At the time of inspection, a new hospital director, the fourth since December 2014, had been in post for six weeks. A new CAMHS consultant was due to take up post December 2015.

- We saw in the clinical governance meeting minutes for January, February and March 2015, that concerns were raised about how staff reported incidents, in relation to the accuracy of incident reporting and what staff viewed as an incident. There appeared to have been no consideration given to understanding why staff had reported what they perceived to be incidents, or to identify potential training needs. The actions taken to manage the quality of incident reports through reducing their number appeared to reflect a senior management view that some risks had been over-rated. Because of this, there was a risk that there would not be effective external oversight of the full scope of incidents occurring within the service.
- The provider's own process was that incident reports should be checked and signed off by the most appropriate senior person on the site. We found that sign off for incident reports had been significantly delayed for many incidents. We requested information about incident reports currently `in progress` and found that 60%, or 90 out of 150 incident reports were still `in progress` two months after the incident date. We also found incidents had been `signed off` in large clusters, for example 31 incidents signed off on 17 June 2015, and then 102 had been signed off on 29 September 2015. This was not an effective way of ensuring senior oversight and checking of the quality and accuracy of the reporting process, and it did not ensure an effective audit trail and clinical overview of quality and safety of care. We also noted that sign off or `finalised` dates had changed for a number of incident reports reviewed, when cross referencing with provider incident data. This meant there was not a clear audit trail of when reports were actually finalised. The provider was taking action to establish why this had happened.
- Our review of the provider's quality improvement lead weekly incident reports from January 2015– October 2015 indicated that a number of concerns had been highlighted, internally, in relation to the detail, quality and completion of incident reports. However, the reports had not identified potential issues in relation to the management of incidents, or that there were a sizeable number of moderate and serious incidents that required further investigation. For example, through our own review of the information available we identified an incident of restraint and treatment under section 5(2) of the Mental Health Act, and we also identified incidents involving multiple restraints and repeat use of intra-muscular rapid tranquilisation within two or three hours for individual patients. Each of these incidents was potentially serious and should have warranted the provider's full investigation to ensure actions taken were in line with legal and best practice frameworks.
- We reviewed two full sets of clinical governance committee (CGC) minutes and papers, as the CGC was central to the governance structure. We saw no evidence of a hospital internal governance structure; although we were told that many meetings were in place. The CGC minutes were inadequate. They gave very little commentary, contained no outcomes or clear sense of deadlines, and there was no thematic analysis or "so what" questions and answers. Further, no clear learning was recorded.
- Use of restraint is monitored as part of a set of key performance indicators for services, using a `25% of incidents` threshold, this includes all types of restraint, for example full holds or guiding someone away from a situation. The provider's own monitoring threshold showed an upward trend was noted via the restraint threshold monitoring and a plan was agreed with the service to monitor this. However, this plan lacked the detail and depth necessary to give adequate assurance that it would identify if there were a more serious concern with the numbers of restraints taking place. There was also no senior oversight of this plan. Actions identified in the provider's quality performance indicator reports to address this included reviewing restraints during service development and clinical governance meetings. We reviewed monthly meeting minutes covering a period of 6 months and found these were not effective forums within which incidents involving restraint and physical intervention would have been effectively monitored. There was no detail to show that incidents involving restraints were reviewed or discussed within these forums.

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- Providers of services that deliver regulated activities have a statutory obligation to notify the Care Quality Commission of a range of events or occurrences. The purpose of these notifications is so that, where needed, CQC can take follow-up action.It was identified that there had been a number of significant events or occurrences about which the provider had not notified us, and so had not fulfilled its statutory obligations. The provider did not have effective systems in place to ensure that it met, consistently, its statutory obligation regarding notifications.
- However, we have since returned to check that the provider has made improvements required and we found that they have improved a number of their governance and management systems to improve safety.

Leadership, morale and staff engagement

- The lack of substantive hospital director had been placed on the risk register in November 2014. Since that time, the hospital had two interim hospital directors in place until July 2015, and then the current deputy hospital director had acted up until September 2015, which was when the newly appointed hospital director had taken up the post. In discussion with the newly appointed hospital director, they demonstrated a clear understanding of the governance systems and processes that would be necessary to ensure quality and safety within the service. They also recognised the importance of embedding an open reporting culture and effective risk management system.
- At a local level, ward managers were highly thought of by their staff teams and were able to lead with appropriate authority. Staff described morale as good on each of the wards. They told us they were listened to and supported by colleagues and managers.
- Figures supplied to us by the provider indicated there was a low overall sickness rate of fewer than 2% at the hospital. This was positive and suggested that issues such as work related stress, repeat sickness absence or long-term sickness were not a significant problem. However, the sickness figure was in marked contrast to the figure supplied for staff turnover, which indicated that 38% of staff had left the service in the previous 12 months. This was a high staff turnover, which may potentially have undermined consistency and quality of service provision, and it required the provider to carry out further analysis to understand why so many staff had left or moved on in such a short space of time. A workforce strategy was in place, but it was very much focused on specific areas of recruitment and retention and was not yet fully developed, as there were no specified deadlines or defined outcomes.
- Staff described morale as good on each of the wards. They told us they were listened to and supported by colleagues and managers, they could challenge senior colleagues about clinical decisions, and that they felt able to speak out if they had any concerns. For example, staff on Skylark ward told us that they had raised concerns about the unit being upstairs on the top floor, as it had an effect on the current patients and possibly restricted the types of people they were able to admit. Managers had told staff that a stair lift was to be installed to mitigate the issue. It has not been installed at the time of inspection, and staff told us they were not aware of any plans or dates for installation. However, staff told us they had felt listened to through the discussions. A senior member of staff on Kingfisher ward told us they felt that joint working had improved considerably in the last two years, due to staff changes but also because in house training had been useful for helping to staff understanding each other's roles. Another member of staff on Kingfisher ward told us it was a great team, very friendly and had no hierarchy at all.
- We found that staff were offered insufficient opportunity to give formal feedback on services and the systems and processes for staff engagement did not seem sufficiently robust. There was no evidence of formalised staff consultations taking place in the last two years. Staff had been spoken to in relation to the move of a ward, but we saw no evidence of any written consultation. There was no staff union council or equivalent, although there was a staff forum that the hospital managers attended and which up to 10 staff representatives were able to attend. However, we were told that on average only three or four staff attend.

Commitment to quality improvement and innovation

- The eating disorders unit on Skylark ward was taking part in the quality network for eating disorder (QED) accreditation scheme, through the Royal College of Psychiatrists. The QED accreditation is designed to

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

enable a service to demonstrate where it is currently meeting national requirements and supports the service to meet them where it is not. They were in the final stages of accreditation at the time of our inspection, but we were subsequently sent confirmation from the hospital director that the hospital had received QED accreditation shortly after our visit.

- The ward manager on Sandpiper ward told us they were looking also at seeking similar accreditation under the Royal College of Psychiatrists scheme, although no timescale had been set on this. Medical staff we spoke with on Sandpiper ward told us they felt supported in undertaking research and making improvements to the service. An example we were given was research into trans cranial magnetic stimulation in the treatment of depression.
- The newly appointed hospital director was extremely positive during discussion and talked enthusiastically about improving processes and systems at the hospital for the benefit of patients. They acknowledged and responded openly and constructively to feedback from inspectors during and after our inspection visit. Following our visit we saw immediate evidence of the hospital director making improvements at the service, and were encouraged that they would take a key role in making necessary changes to drive wider long term improvement in the quality of service provision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must take steps to ensure risks to patients are identified, assessed and monitored consistently on each ward, and that action plans in assessments and care plans are updated and contain sufficient detail to enable staff to mitigate effectively those risks. The registered person did not demonstrate that they had fully assessed all the risks related to the health and safety of service users receiving care or treatment and had not done all that was possible to mitigate those risks. They had not ensured the premises were safe for their intended purpose and used in a safe way. Risks associated with the physical ward environment, such as ligature points, had not been fully assessed and effectively mitigated. While there were systematic measures in place to report and record safeguarding allegations and concerns, these were not implemented consistently in line with the Priory Group safeguarding policies, which reduced internal and external oversight. This is a breach of regulation 12 (2) (a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission of all incidents specified in the regulation. This had included: abuse or allegations of abuse in relation to a service user; and any incident which is reported to, or investigated by the police.

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 18 (1),(2)(e)(f)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We were concerned that inconsistent, inaccurate recording and reporting of incidents meant that the provider could not be assured that incident data was accurate and reflected the actual number or detail of incidents. Reduced senior oversight, in particular related to the inconsistent investigation of moderate and serious incidents meant that the risks within the service may not be identified and addressed in a timely manner. Potential trends or near misses may not be identified to learn from and prevent future incidents. Additional quality assurance processes had not effectively identified the issues around consistency, or put in place effective action plans to address this. For example, additional support and training for staff. This had the potential to impact on how risks were identified and subsequently recorded across the service. This was a breach of regulation 17 (2)(a)(b)(c)